Michigan Cancer Surveillance Program

Abstract Plus User Manual
Version 4

Effective for cases diagnosed ON or PRIOR to December 31, 2012

Registry Plus Software for Michigan Registries

(Based on Abstract Plus Version 3.2.1.0)

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Table of Contents

Chapter 1: Introduction

Overall Learning Objectives

The overall learning objectives for the MCSP Abstract Plus User Manual are:

- Learn how to Log into Abstract Plus version 3.2.1.0
- Learn about the Abstract Plus menu items
- Become familiar with the basic steps for abstracting using Abstract Plus
- Learn how to begin abstracting by starting a new abstract, opening an existing abstract, or copying an existing abstract
- Become familiar with the abstracting features of Abstract Plus, including entering text fields, coding histologic type, and coding and deriving Collaborative Staging fields
- Learn about the Abstract Plus editing features and how to correct edit errors
- Learn how to print abstracts
- Learn how to export abstracts out of Abstract Plus
- Become familiar with Abstract Plus Utilities
- View, print, save available abstract reports, and run custom reports

Overview of the MCSP Abstract Plus User Manual Version 4

The Michigan Cancer Surveillance Program (MCSP) Abstract Plus User Manual version 4 provides you with step-by-step instructions for all the procedures performed through *MI Abstract Plus Version 3.2.1.0*. For detailed instructions on data item completion, please refer to the *MCSP Cancer Reporting Manual* at http://michigan.gov/mdch/0,1607,7-132-2945_5521-16586__,00.html.

The major sections in this manual include an Introduction, Abstract Plus General User Basics, Working with Abstracts: Data Entry Procedure, Saving Abstracts, Correcting Edit Errors, Importing Abstracts, Exporting Abstracts, Printing Abstracts, Abstract Plus Utilities, Running Reports, and a Flowchart for Hematopoietics and Lymphoid Neoplasms.

The **specific coding instructions for completing each data item** on the *Michigan Cancer Report Form* and in Abstract Plus can be found in the *MCSP Cancer Reporting Manual*. These coding instructions **must be followed to complete the abstract in Abstract Plus**.

Abstract Plus Features

Abstract Plus v3.2.1.0 is effective for cases diagnosed ON or PRIOR to December 31, 2012.

Abstract Plus version 3.2.1.0 is a free-of-charge, cancer data collection tool developed by the Centers for Disease Control and Prevention (CDC). A customized version for the Michigan central cancer registry enables facilities within the State to report cancer cases to the Michigan Cancer Surveillance Program electronically. Although the product is not designed to include all functionality needed in an ACoS-approved hospital cancer registry, it is suitable for reporting to central registries from non-registry hospitals, clinics, laboratories, and other sources for cancer incident reports.

The abstracting capability of Abstract Plus is used to summarize medical records into an electronic report of cancer diagnosis and treatment by abstractors or anyone working with cancer data. Abstract Plus supports the abstraction of all data items in national standard data sets, including all text fields, as well as, any state-specific data items. The output of Abstract Plus is an electronic abstract in the format of the North American Association of Central Cancer Registries (NAACCR) data exchange layout.

Abstracts entered into Abstract Plus are validated by customizable edits, allowing for an interactive error correction while abstracting. Abstract Plus includes Registry Plus Online Help, a collection of standard coding manuals that are cross-referenced, indexed, and context-linked to minimize the need to reference printed manuals during abstracting.

Abstract Plus version 3.2.1.0 has been entirely reprogrammed using .NET technology. The application has a new, more user-friendly abstracting interface. New direct grid entry of coded values allows for a more streamlined abstracting experience, as well as, easier viewing of text fields, online help, and edit errors.

For Michigan, the MCSP Abstract Plus User Manual overrides the Generic Registry Plus Online Help Abstract Plus Users Guide.

Abstract Plus version 3.2.1.0 also has enhanced security features. All records are saved in Microsoft Access or SQL server databases, and all tables are password protected and encrypted using Microsoft functions. All users must have a User ID and password to access the abstracting features of the application.

System Requirements

Abstract Plus is programmed for the Microsoft Windows 32-bit environment installed on an Intel Pentium or Pentium-compatible computer. The application can also be installed on a 64-bit environment. The minimum hardware requirements are the same as those of the Microsoft Windows operating system used. Additional system requirements include:

System Component	Client Computer
RAM	500 MB or more
Hard Disk	200 MB of free space
OS	Windows XP or later
.NET Framework	Version 3.5 or later

Downloading and Installing Abstract Plus

Before You Install or Re-install (Upgrade) Abstract Plus version 3.2.1.0, you **must** contact Terry McTaggart for technical support at mctaggartT1@michigan.gov or 517-335-9624.

If you have a prior version of Abstract Plus installed on your computer, and would like to upgrade to Abstract Plus version 3.2.1.0, there is no automatic upgrade available. **Do NOT uninstall your current version, as you will need to export ALL abstracts out of your current version of Abstract Plus.**

User Support

For technical support, contact Terry McTaggart at mctaggartT1@michigan.gov or 517-335-9624.

For abstracting support, contact MCSP field representative Jetty Alverson at alversong@michigan.gov or 517-335-8855.

MCSP Cancer Program Manual

The Michigan Cancer Surveillance Program (MCSP) Cancer Program Manual provides information on the administrative rules on cancer reporting and Michigan reporting facility responsibilities, as well as, detailed instructions on coding, e.g., preparation of the cancer report form, follow-up work on reported cases, reportable conditions, ambiguous terminology, case finding procedures and components of good reporting. A copy of the manual can be downloaded from the State of Michigan Website at http://www.michigan.gov/mdch/0,1607,7-132-2945_5221-16586--,00.html.

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Chapter 2: Abstract Plus General User Basics

Learning Objectives

In this chapter, you will learn to:

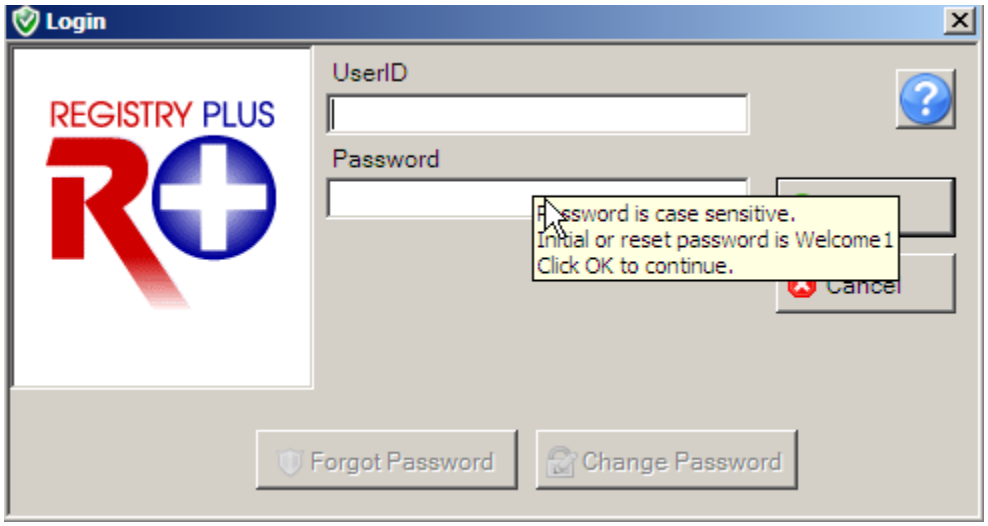
- Open Abstract Plus and log in
- Change your general user password
- How to reset your password if forgotten
- Exit Abstract Plus and use the Backup option
- Use the Restore option to restore your abstracts database if corrupted
- Familiarize yourself with the Abstract Plus main window and abstracting menu options

Logging in to Abstract Plus

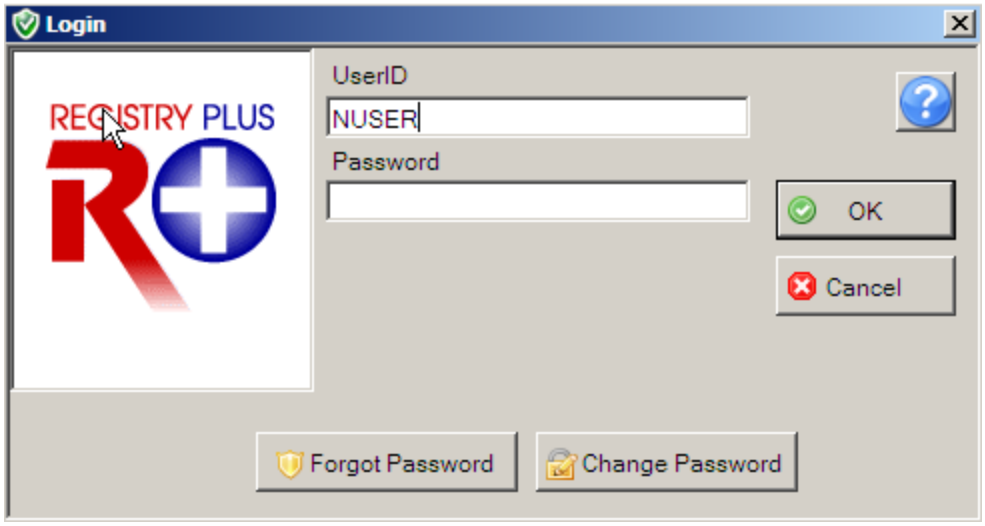
For routine log in to Abstract Plus, complete these steps.

1. Click on the **Abstract Plus** icon.

   Result: The **Login** window opens.



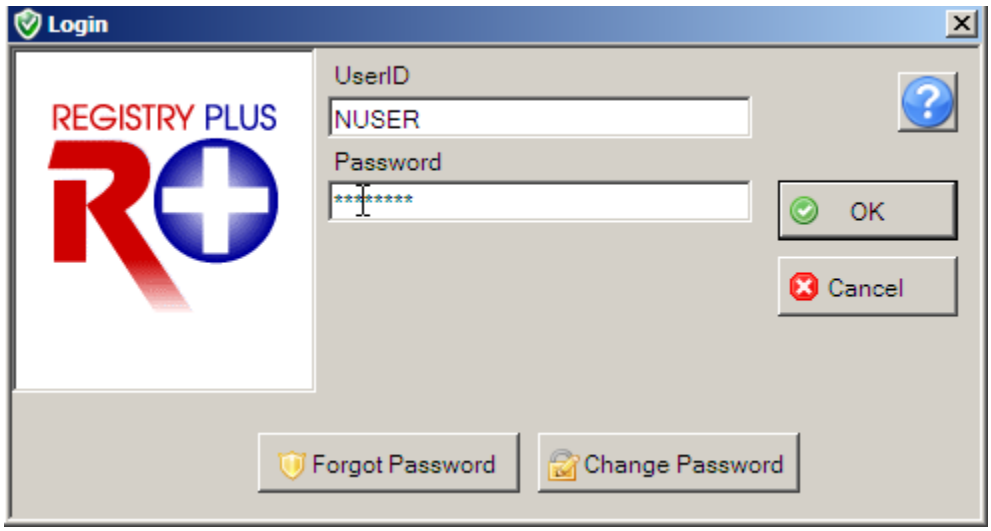
2. Enter your **User ID** in the **User ID** box. In the example shown, the User ID being entered is NUSER.



3. Enter your **password** in the **Password** box, and click **OK**.

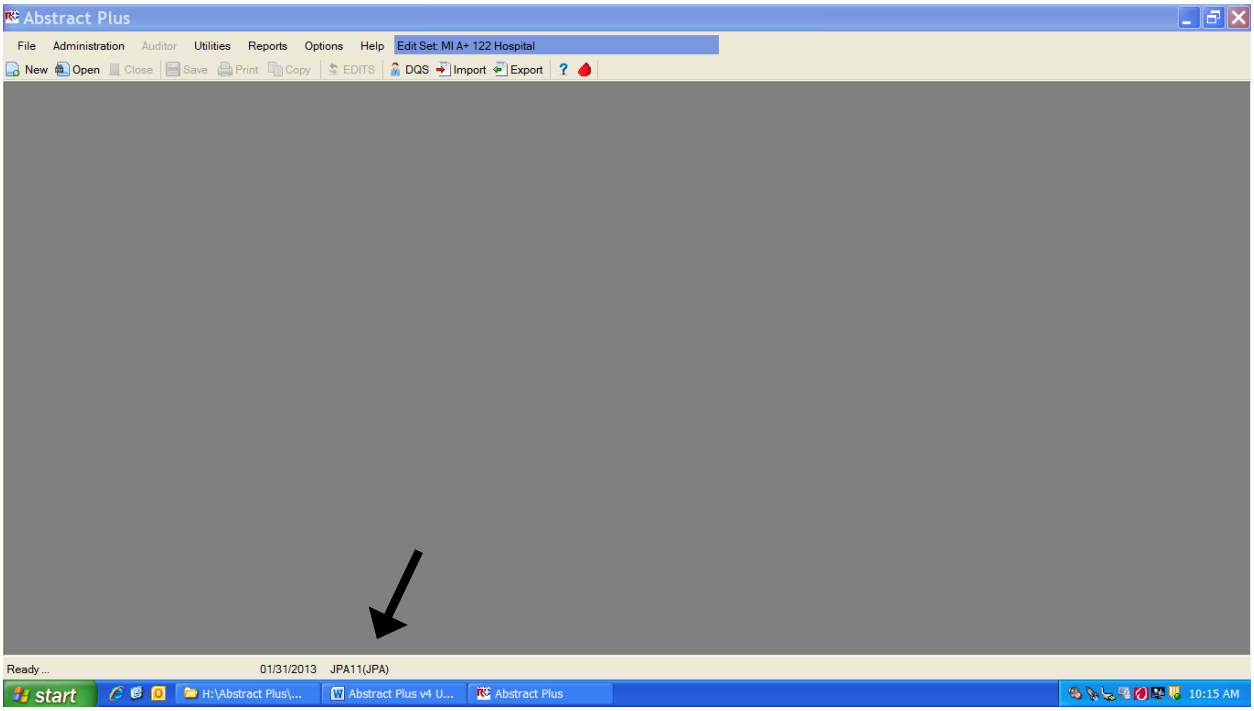
Note

When entering your password, asterisks will be displayed rather than your password for added security. Note that passwords are case sensitive.



Result: The Abstract Plus **main window** opens, with you logged in as a general user. Note that your User ID is displayed at the bottom of the window.

When logged in with your own user ID and password, you are recorded as the abstractor when creating new abstracts. This information can be used as selection criteria for reports and exports, and can also be used for general tracking purposes to associate abstractors with their specific abstracts.

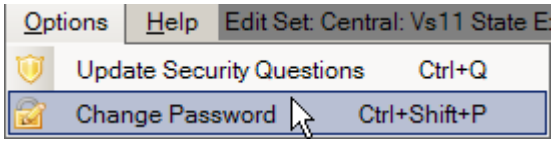


To **Create a New Abstract**, go to Chapter 4 (CreatingaNewAbstract4).

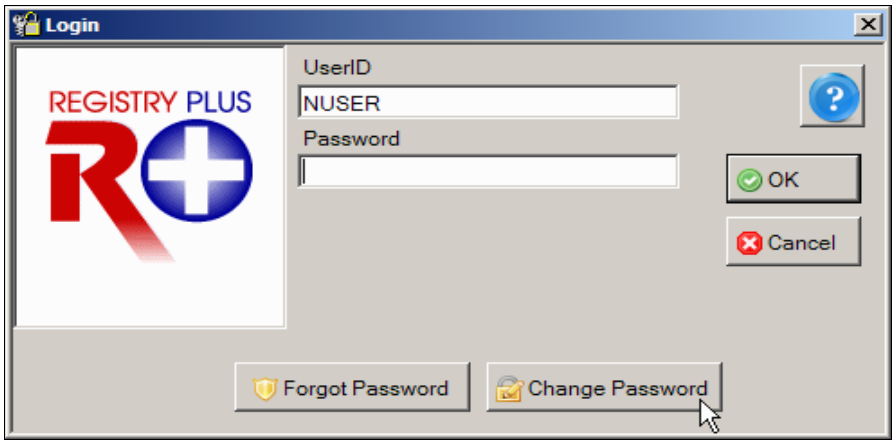
Changing Your General User Password

For security purposes, you may be prompted to change your general user password periodically. To change your Abstractor/general user password, complete these steps.

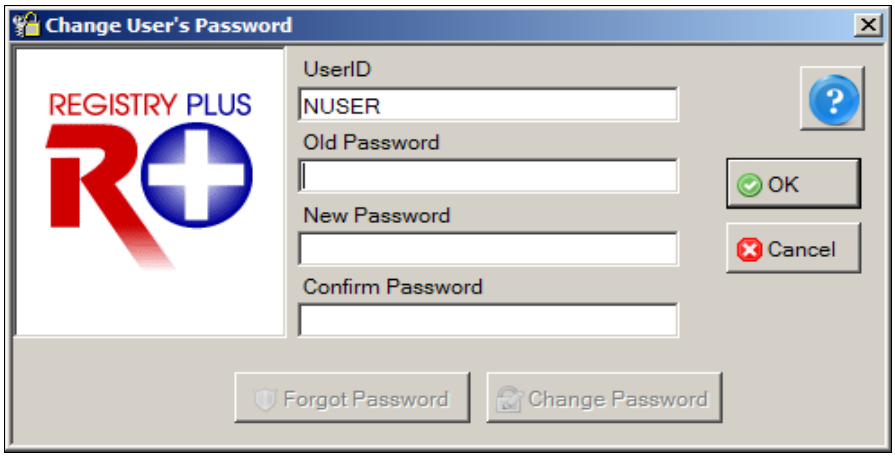
1. Open the **Change User's Password** window. This may be done in two ways.
    a. From **Options Menu**, select **Change Password.**



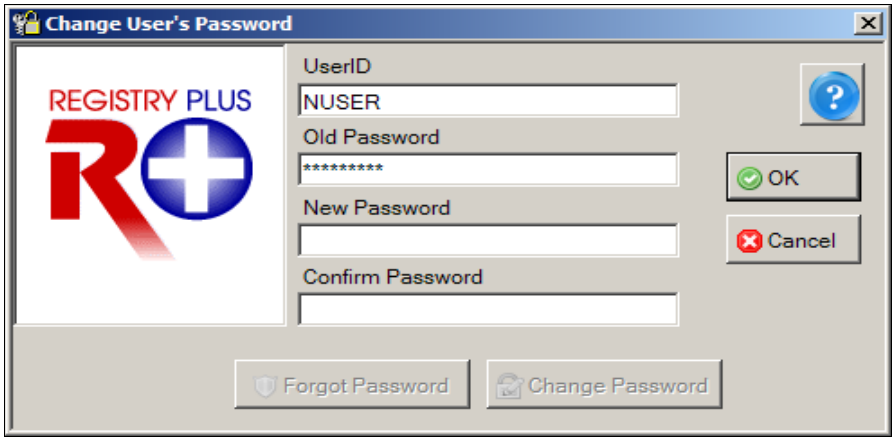
    b. When logging in to Abstract Plus, enter your **User ID**, tab or click into the Password box, and then click **Change Password** on the Login window.



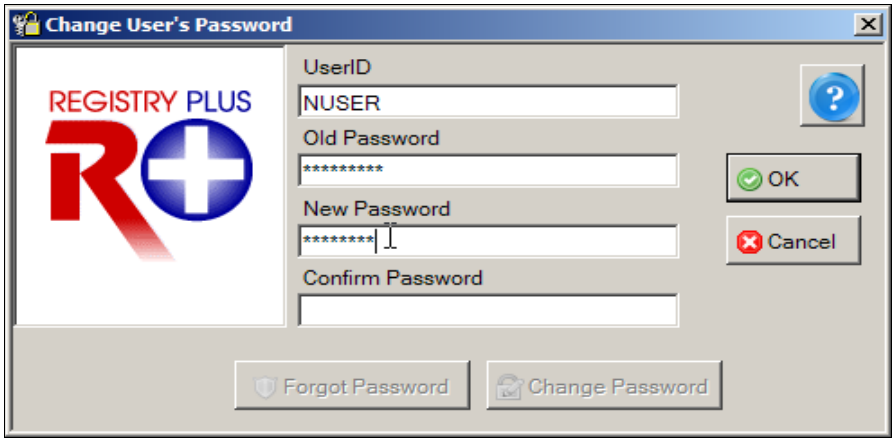
Result: The **Change User's Password** window opens with your User ID displayed.



2. Enter your **Current Password** in **Old Password** box.



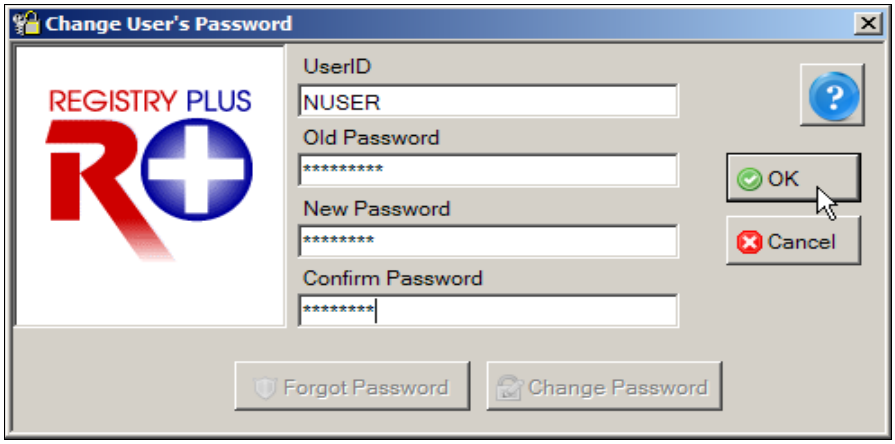
3. Enter a **New Password** in the **New Password** box, which meets the password requirements specified by your Abstract Plus Administrator.



Note

If your Administrator has made no changes, by default, your new password must be between 8 and 20 characters, contain at least one digit and one alphabetical character, and may not contain any special characters.

4. Re-enter your **New Password** in the **Confirm Password** box.



5. Click **OK** to change your password.

   Result: Your password is changed, and the Abstract Plus main window is opened.

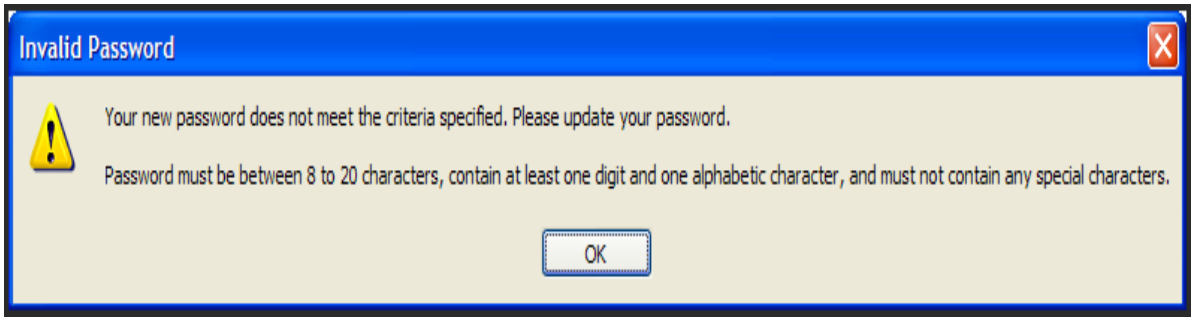
Possible Errors when Changing Your Password

There are three possible errors you may receive when attempting to change your password.

1. **Old password is incorrect**. You must correctly enter your old password in order to successfully change it. Click **OK**, and then correctly re-enter your old password.

2. **New passwords do not match**. The new password entered into the **New Password** and **Confirm Password** boxes must match exactly. Click **OK**, and then correctly re-enter your new password in the New and Confirm password boxes.

3. **New password does not meet specified password requirements**. To meet system requirements, your new password must be 8 to 20 characters, contain at least one digit and one alphabetic character, and may not contain any special characters. Click **OK**, and then re-enter a new password that meets the stated password requirements.



Resetting a Forgotten Password

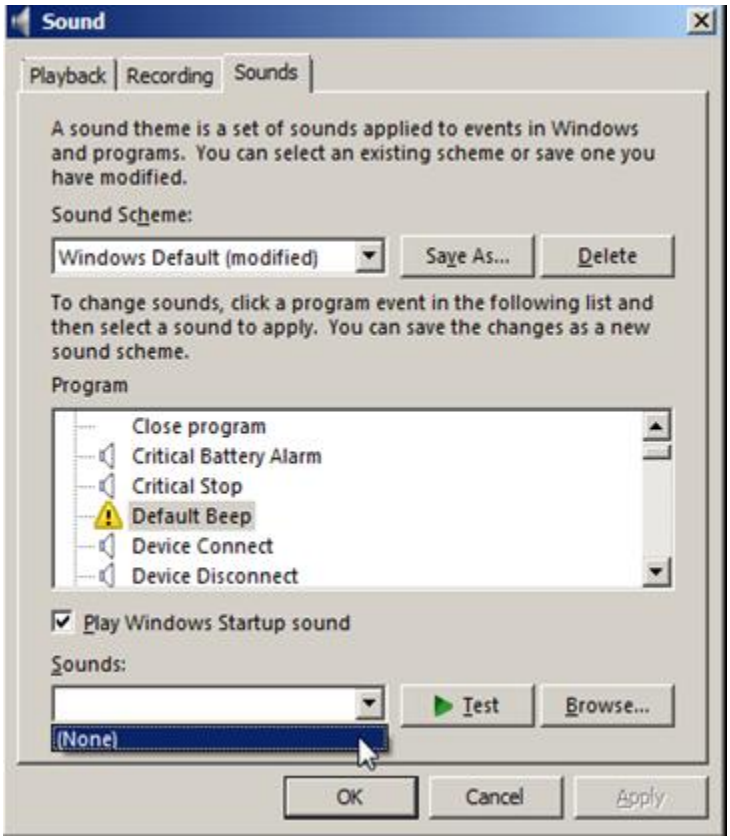
In the event that you should forget your password, you will need to contact your Administrator to reset your password for you.

The Abstract Plus Main Window

The Abstract Plus main window provides access to all the application's features. Your User ID is displayed at the bottom of the window, today's date, and important system messages in the lower left-hand corner of the window. The default edit set is displayed in the upper center of the window. When logged in as an Abstractor, you will automatically have access to all of the

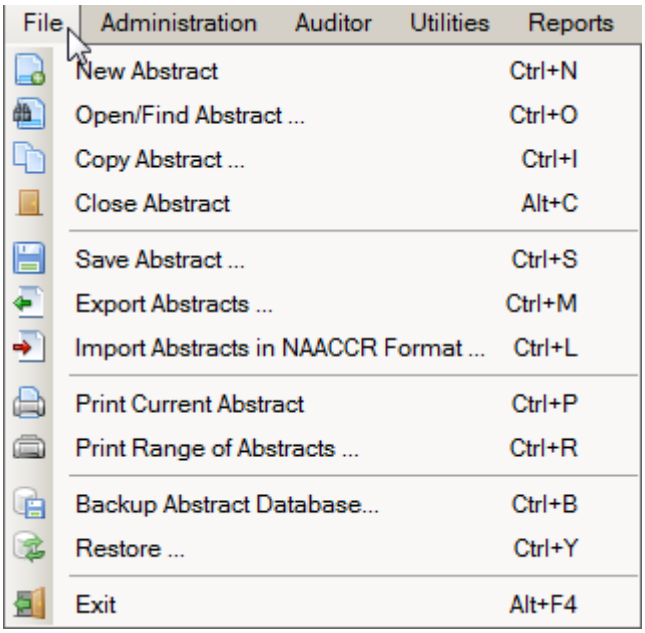
application's abstracting features via the main menu items. Some menu options are also available as buttons in the toolbar as shown below.

By default Microsoft comes with sound effect features; one of those features is a "beep" feedback sound in response to pressing the tab or enter keys. If you do not like these sounds being issued as you use Abstract Plus, you can turn them off by going to Start→Settings→Control Panel→Sounds (Sounds and Audio Devices)→Sounds Tab→ select Sound scheme: no sound→ select Default Beep→select Sounds: (None) from the Sounds pull-down menu→Click OK.



The File Menu

The File menu is used to access the majority of features that are used to work with abstracts. To access the File menu items, click on the **File** menu item, and select the desired sub-option, or use the appropriate keystroke combination for the desired sub-option.



The following table describes the Abstract Plus File menu sub-options and keystroke combinations.

Sub-option (Keystroke)	Toolbar Icon	Function
New Abstract (Ctrl+N)	New	Create a new abstract
Open/Find Abstract (Ctrl+O)	Open	Search for and open an existing abstract
Copy Abstract (Ctrl+I)	Copy	Copy an opened abstract
Close Abstract (Alt+C)	Close	Close an opened abstract
Save Abstract (Ctrl+S)	Save	Save entered information
Export Abstracts (Ctrl+M)	Export	Export abstracts out of the Abstract Plus database into a NAACCR-formatted file
Import Abstracts in NAACCR Format (Ctrl+L)	Import	Import abstracts in a NAACCR-formatted file into the Abstract Plus database
Print Current Abstract (Ctrl+P)	Print	Preview the displayed abstract and/or print it
Print Range of Abstracts (Ctrl+R)		Select and print a range of abstracts or save in a file

Sub-option (Keystroke)	Toolbar Icon	Function
Backup Abstract Database (Ctrl+B)		Create a backup database to be used by Restore feature if database becomes corrupted
Restore… (Ctrl+Y)		Restore/replace corrupted database with a previously saved backup database
Exit (Alt+F4)		Log off Abstract Plus with an option to back up the database with your work

The Administration Menu

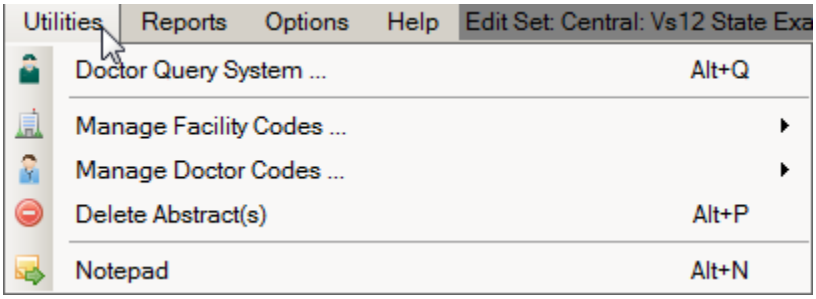
The Administrative functions can **only** be accessed by the Administrator. For more information, refer to the MI Abstract Plus Installation Instructions for version 3.2.1.0.

The Audit features of the program have been temporarily disabled.

The Utilities Menu

The Utilities menu is used to access a few supplementary functions included in the program, such as re-running edits in batch mode, querying your local database of doctors, managing facility and doctor codes, and deleting abstracts.

To access the Utilities menu items, click on the **Utilities** menu item, and select the desired sub-option, or use the appropriate keystroke combination for the desired sub-option.



The following table describes the Abstract Plus Utilities menu sub-option and keystroke combinations.

Sub-option (Keystroke)	Toolbar Icon	Function
Doctor Query System (Alt+Q)		Query and search the doctor database; DQS can be accessed whether or not an abstract is opened, or a physician field is selected
Manage Facility Codes…		Import (can use Alt+I keystroke) or edit (can use Alt+J keystroke) local facility codes
Manage Doctor Codes		Import (can use Alt+K keystroke) or edit (can use Alt+L keystroke) local physician codes
Delete Abstract(s) (Alt+P)		Delete selected abstracts
Notepad (Alt+N)		Launch Notepad to view created text files

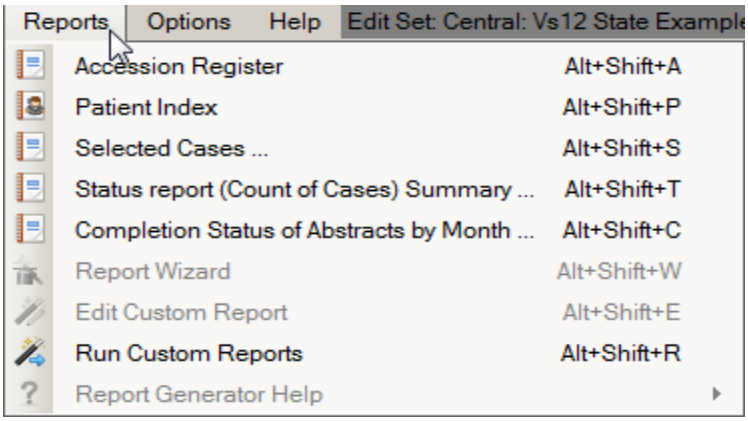
The initial list of Facility Codes was added to Abstract Plus version 3.1.2.5. The codes are located in the Manage Facility Codes utility function; however, if you need to add or delete an individual facility to or from the list, you must contact the MCSP first for user support. For user support, go to page 5.

The Reports Menu

The Reports menu is used to access all of the available reports regarding abstracts in the Abstract Plus database. No toolbar icons are available for any Reports menu options.

The Report Wizard, Edit Custom Reports, and Report Generator Help functions have been temporarily disabled.

To access the Reports menu items, click on the **Reports** menu item, and select the desired report, or use the appropriate keystroke combination for the desired report.



The following table describes the available Abstract Plus Reports menu sub-option and keystroke combinations.

Sub-option (Keystroke)	Function
Accession Register (Alt+Shift+A)	Opens the Accession Register Report, which includes a line listing of all abstracts in the database, sorted by reporting hospital and accession number
Patient Index (Alt+Shift+P)	Opens the Patient Index Report, which includes a line listing of all abstracts in the database, sorted alphabetically by name
Selected Cases (Alt+Shift+S)	Opens a line listing report which includes abstracts based on user-specified criteria
Status Report (Count of Cases) Summary (Alt+Shift+T)	Opens a report that includes the total number of complete and incomplete abstracts by export status within a user-specified date range
Completion Status of Abstracts by month (Alt+Shift+C)	Opens a report that includes abstract completion status by year and month of Date of Adm/First Contact within a user-specified date range
Run Custom Reports (Alt+Shift+R)	Runs selected custom reports that have been added to the application using the Report Wizard

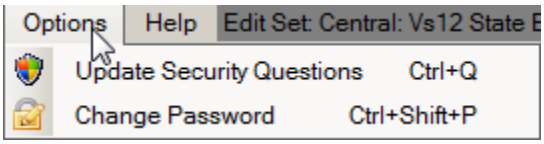
For more information on **Running Reports**, go to Chapter11.

The Options Menu

For security purposes, users may want to change their passwords on a routine basis.

The Update Security Questions function is not available in MI Abstract Plus version 3.2.1.0.

To access the Options menu items, click on the **Options** menu item, and select the desired sub-option, or use the appropriate keystroke combination for the desired sub-option.

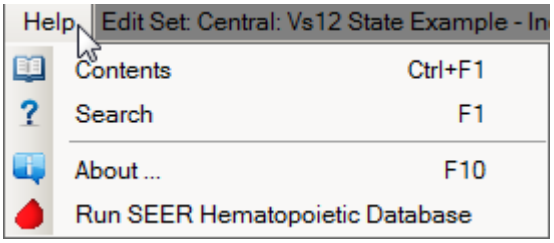


The following table describes the available Abstract Plus Options menu sub-option and keystroke combination.

Sub-option (Keystroke)	Function
Change Password (Ctrl+Shift+P)	Opens the Change User's Password window where the user can change their current password

The Help Menu

The Help menu is used to access the online help that is available within the program. To access the Help menu items, click on the **Help** menu item, and select the desired sub-option, or use the appropriate keystroke combination for the desired sub-option.



The following table describes the Abstract Plus Help menu sub-option and keystroke combinations.

Sub-option (Keystroke)	Toolbar Icon	Function
Contents (Ctrl+F1)		View the contents of Abstract Plus online Help
Search for help on… (F1)		Enter search terms for topics on which you need more information
About (F10)		View Abstract Plus, Collaborative Staging, and Edits metafile information
Run SEER Hematopoietic Database		Launch the SEER Hematopoietic Database stand-alone application to help you code hematopoietic and lymphoid neoplasm cases diagnosed beginning January 1, 2010

Chapter 3: Abstracting Window and Editing Features

Learning Objectives

In this chapter, you will learn:

- How to use the Abstract Plus abstracting window and editing features
- To recognize the color-coded edits error count and abstract completion status
- How to enter dates in Abstract Plus Version 3.2.1.0
- To identify the special features to facilitate the abstraction and deriving of Collaborative Staging input fields
- How to code histologic type for hematopoietic and lymphoid neoplasms
- How to use the Notepad function

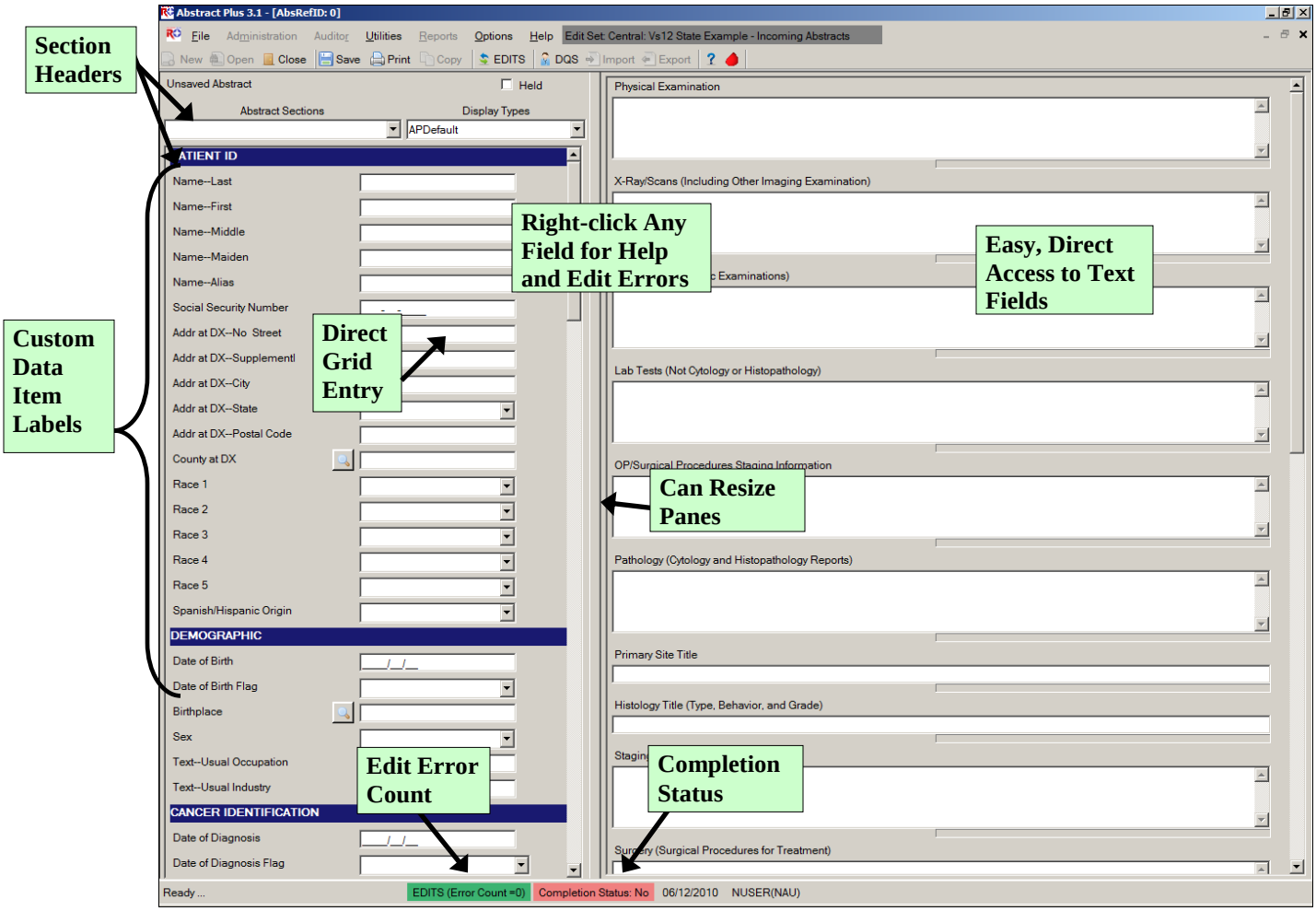
Abstract Plus Abstracting Window

As mentioned, Abstract Plus version 3.2.1.0 has been entirely reprogrammed using .NET technology, and has a new, extremely user-friendly abstracting interface. New direct grid entry of coded values and quick select options for pull-down menus allow for an easy, streamlined abstracting experience, as well as, easier viewing of text fields, online help, and edit errors.

The Abstract Plus Abstracting window is divided into two main sections: a data entry grid for coded values on the left, and a data entry grid for text fields on the right. When you left-click and hold your mouse on the vertical divider bar in the center of the window, a splitter is highlighted which you can drag to the left or right to resize the view of codes or text fields, and the application remembers your last placement of the divider bar. You can vertically scroll the view of coded values and text fields independently to easily and concurrently view codes and associated text.

The abstracting interface is called a **display type.** A display type basically includes information regarding the fields displayed/collected, critical (or required) fields, edit set selections, and collaborative staging preferences. The display type is configured by your Abstract Plus Administrator upon setup of the application. The data items in a display type are labeled and ordered by your Administrator, as well as, grouped into logical sections, which also have customizable labels.

Regardless of the customized label a data item may have, when a data item is selected, the associated NAACCR item name is always displayed in the lower left-hand corner of the window. This is helpful when looking up information regarding a data item in the online help reference books.



Note

In the example shown above, the screen shot of the Abstract Plus Abstracting window was taken from Abstract Plus version 3.1. The basic process of generating and updating an abstract has not changed from version 3.1 to 3.2.

Recall that the basic process of generating and updating an abstract is as follows.

i. Create the abstract with the patient's identifiers, such as name and social security number and save. After you create an abstract, you can save it at any time and return to your work at a later time.

ii. Enter codes and text in the data entry fields. Save the abstract to retain the information you have entered.

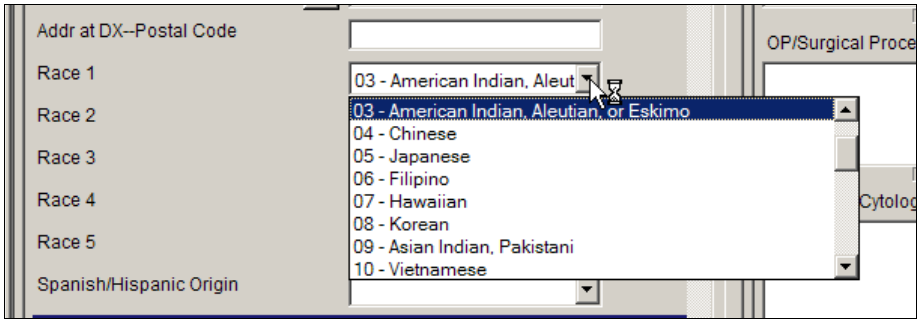
iii. Correct errors. Each time you open or save the abstract, Abstract Plus can automatically edit the entered information for accuracy and completeness using the edit set and required fields chosen by your Abstract Plus Administrator.

iv. After you have entered all your data and corrected all errors, the system saves your new abstract as complete. You will see the edits error count and completion status indicators

at the bottom of the abstracting window turn from red to green, indicating that the abstract is complete.

The Abstractor uses the following abstracting features of the abstracting window to enter information regarding the patient and tumor being abstracted.

a. Many data items offer **code selection from pull-down lists**. In addition, the pull-down lists feature an auto-complete, **find-as-you-type** function that allows the user to type in the first letter, or first few letters, of the desired code label, and the application auto-selects the first item in the list beginning with that letter. In the example shown below, an A has been typed into the Race 1 field, and the application auto-selects the value of American Indian, Aleutian, or Eskimo.



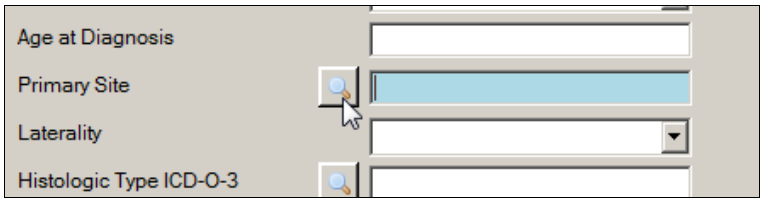
Important

Once the curser is in the field and the particular pull-down list is displayed, the user must either use the up and down arrow keys or use their mouse to make their selection.

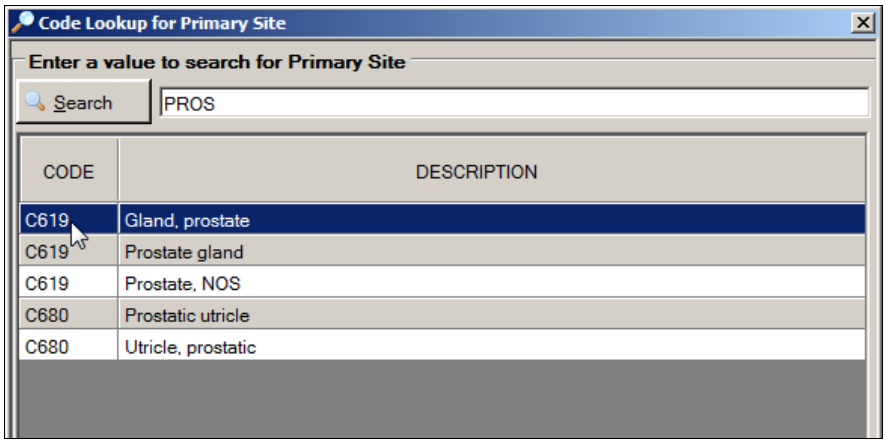
Tip

If you begin typing in the data item, but find you need to revise what you have typed, press the backspace key to delete what you have already entered, and start typing again. This enables the find-as-you-type feature to automatically find your revised entry.

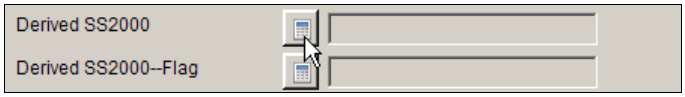
b. For data items with extensive listing of coded values, such as histology, there is lookup assisted data entry with an **advanced search feature**. You can either enter the code directly if known, or click on the magnifying glass icon to the left of the data item (or press F4) to use the search feature.



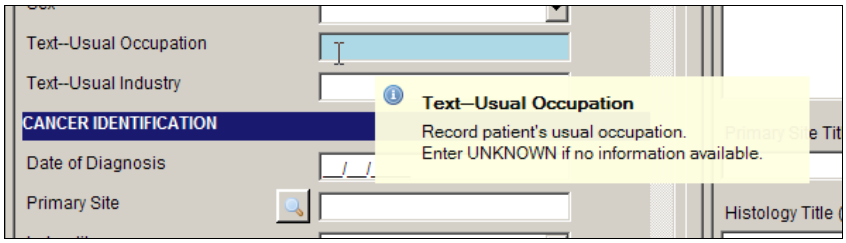
Enter a full or partial search term or code to search for, and then double-click on the code of your choice to transfer the value to the data item in the data entry grid.



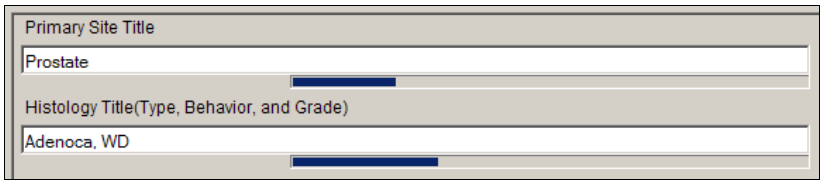
c. Depending on the system preferences set by your Abstract Plus Administrator, users can **automatically calculate Age at Diagnosis** once date of birth and date of diagnosis are entered, and can **calculate Collaborative Staging** by clicking on the calculator icon to the left of the data item.



d. **Prompt messages** may be associated with each data item, so that when the abstractor clicks into the field, a pop-up box comes up with a message or instructions about abstracting that field.

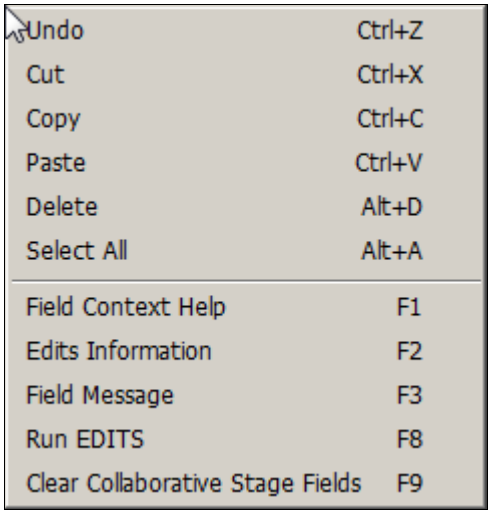


e. When entering text, a **progress bar** is displayed below each text field indicating how much space is left so that you can properly prioritize the information you are entering.



f. **Keyboard and mouse alternatives** are now available for every function in the software. Note that Keystroke options are displayed on menus for all menu items, and Appendix A of this training manual contains a listing of standard Abstract Plus keyboard shortcuts to functions.

g. All-new **right-click functions** for individual data items, including access to field context help, edits error information, field messages, and a function to clear all Collaborative Stage fields is now available.

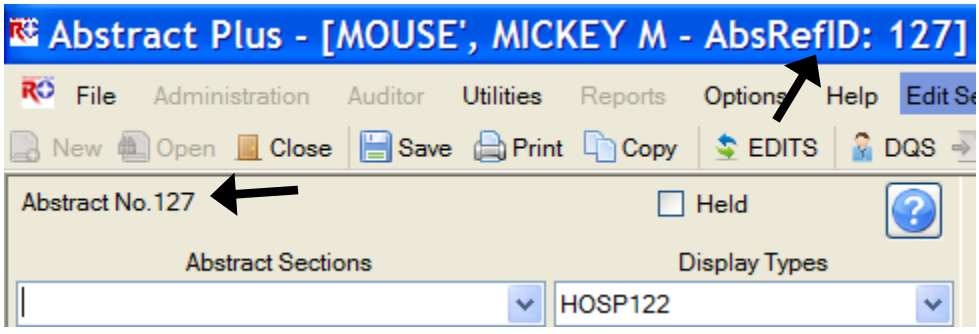


h. **Color-coded edits error count and abstract completion status** information is clearly displayed to the user at the bottom of the abstracting window and changes from red to green upon completion of the abstract.

Incomplete abstract containing edit errors:

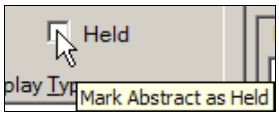
Complete abstract containing no edit errors:

i. Once saved, each abstract is assigned an unique **Abstract Reference ID** (or AbsRefID), displayed in the upper left-hand corner of the data entry area of abstracting window, as well as, in the title bar of the application along with the patient name.



j. **Abstracts can be held to prevent export**. The **Held** check box allows an abstractor to prevent a case from being exported even if it is considered complete by the system. This can be used if, for example, the abstractor is searching for additional information

to be included before the abstract is exported. If checked, the abstract will not be exported, regardless of Completion Status.



Entering Dates in Abstract Plus Version 3.2.1.0

As of the NAACCR 12 record layout, all dates are in the YYYYMMDD format.

Because the NAACCR standards are so tightly integrated with the Abstract Plus program dates are entered in the YYYYMMDD format in Abstract Plus version 3.2.1.0.

The Abstractor will enter dates in the new YYYYMMDD format as follows:

YYYY/MM/DD – when complete date is known

YYYY/MM/**15** – when year and month are known, but day is unknown; record day as the **15th**

YYYY/**07/15** – when year is known, but month and day are unknown; record month and day as **July 15th**

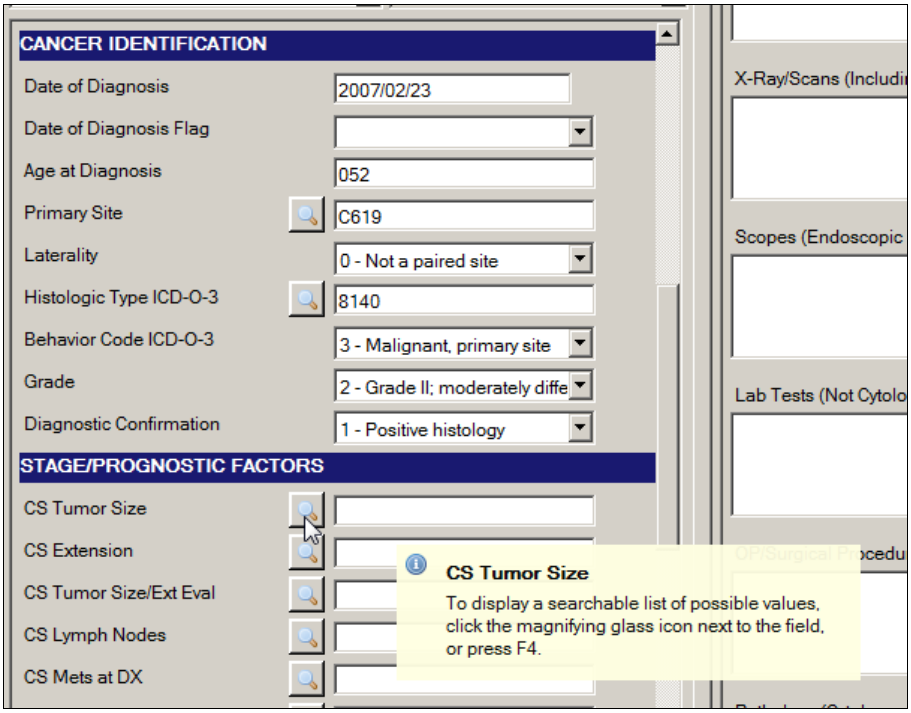
Abstract Plus version 3.2.1.0 has a date field entry mask on all date fields that already has the slashes in it. Although the application allows you to type the slashes and dashes when entering dates fields, you can save keystrokes by **only typing the 8 characters of the date**. For example, for the date of August 1, 2012, the date is entered as 20120801.

Abstracting and Deriving Collaborative Staging Fields

Abstract Plus version 3.2.1.0 has some special features to facilitate the abstraction of Collaborative Staging (CS) input fields, in particular for the Site-Specific Factors (SSFs).

Abstracting CS Input Fields

Once the fields for the primary site and histology have been entered, each CS input data item has a special site-specific look-up associated with it. This can be accessed by **clicking** the **magnifying glass icon** to the left of the field or **pressing F4**.



Abstracting CS SSFs

Abstract Plus allows for automatic defaulting of CS SSFs and the running of edits to identify required CS fields, automatic filling in of CS fields, as well as, the wiping out of CS input fields for cases diagnosed 2003 and earlier.

For the filling of the CS fields, once the Abstractor enters a Primary Site, Histology, DxDate and Behavior (in no particular expected order), the fields of CS Input Current (item #2937) and CS Input Original (item #2935) are both automatically filled **when the Abstractor enters any CS input field**. CS Derived (item #2936) is filled when you derive the CS derived fields.

Once entered, a check on primary site and histology is run to ascertain whether or not SSF25 is required for schema identification.

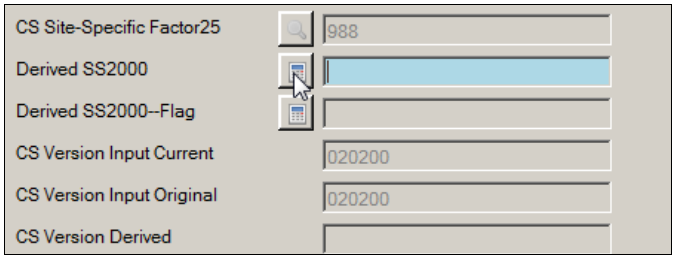
1. If SSF25 is required for the primary site and histology entered.
    a. The SSF25 look-up window for the entered schema will open so that you can select a value for SSF25.
    b. Once you have entered SSF25, automatic defaulting and disabling of SSFs that are undefined for the entered schema will occur. This will enable you to clearly discern what SSFs are not required, and which SSFs are required. The automatic defaulting will delineate what SSFs are not defined for the identified schema, and the running of edits will delineate what SSFs are required.

If the primary site and histology initially entered are revised to result in a different schema, you will be offered the option of clearing all CS input fields and re-coding CS for the abstract. Regardless of whether you clear all values and re-code CS, or keep existing values and modify the codes, the above SSF defaulting routine will run again for the newly entered schema.

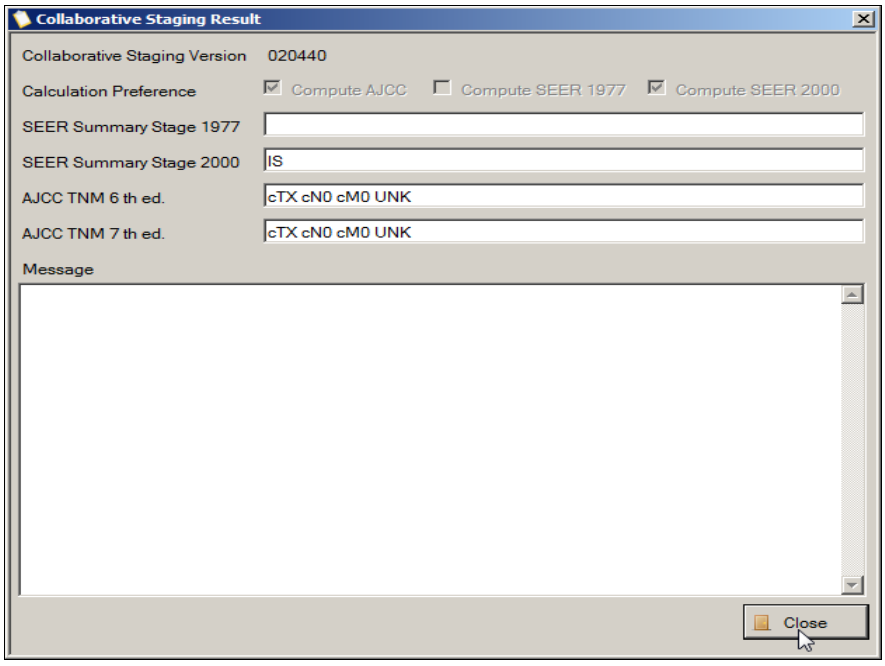
2. If SSF25 is not required for the primary site and histology entered.
    a. SSF25 will be automatically defaulted and disabled.
    b. Automatic defaulting and disabling of other SSFs that is undefined for the entered schema will occur. This will enable you to clearly discern what SSFs are not required, and which SSFs are required. The automatic defaulting will delineate what SSFs are not defined for the identified schema, and the running of edits will delineate what SSFs are required.

Calculating Derived Staging Fields

To derive the staging fields, once the appropriate CS input fields have been entered, place the cursor into any of the derived fields and **press F5** or **click** the **calculator icon** to the left of the field.

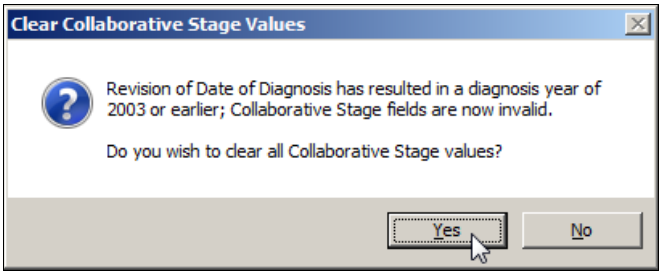


Result: The **Collaborative Staging Result** window open and displays the calculated values.

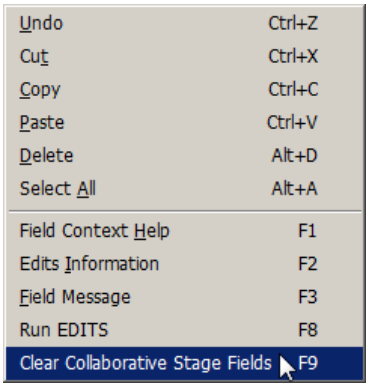


CS Fields and Tumors Diagnosed 2003 and Earlier

One further helpful feature is that upon entry of a Date of Diagnosis of 2003 and earlier, you will be offered the option of clearing all CS fields.



The Clear Collaborative Staging Values window opens automatically upon entry of a diagnosis year of less than 2004. However, you can clear Collaborative Staging fields at any time by using the **right-click function** to Clear Collaborative Stage Fields or **pressing F9**.



Abstracting Histologic Type for Hematopoietic and Lymphoid Neoplasms

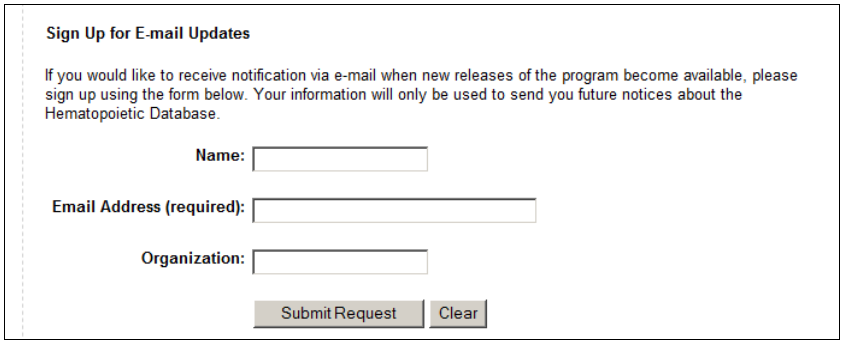
Prior to cases diagnosed in 2010, coding of Histologic Type in Abstract Plus entailed using the advanced search feature for the Histologic Type field: click the magnifying glass icon to the left of the field, enter a search term in the search window that opens, and double-click the histologic code that is listed for the specific term for which a search was conducted.

However, new reportability instructions and data collection rules for hematopoietic and lymphoid neoplasms have gone into effect for cases diagnosed beginning January 1, 2010. As a result, two tools have been developed by SEER for use beginning in 2010: The Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual, and the Hematopoietic Database. The Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual comes within the Hematopoietic Database; contains reportability instructions and rules for determining the number of primaries, the primary site, histology, and tumor grade.

The Hematopoietic DB is a stand-alone application developed to assist in screening for reportable cases and determining reportability requirements, and contains abstracting and coding information for all hematopoietic and lymphoid neoplasms (9590/3-9992/3).

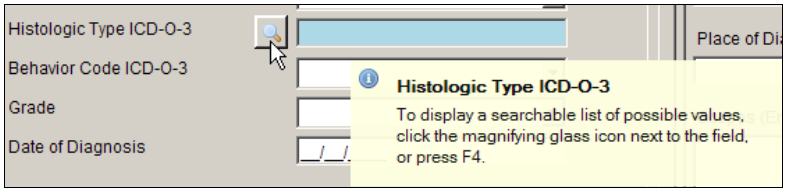
Important

The SEER Hematopoietic Database must be independently installed and maintained by the Abstractor. It can be downloaded from the following URL: http://seer.cancer.gov/tools/heme/. In order to stay abreast of revisions in the database, it is recommended that you sign up on the website to receive e-mails when the database is updated.

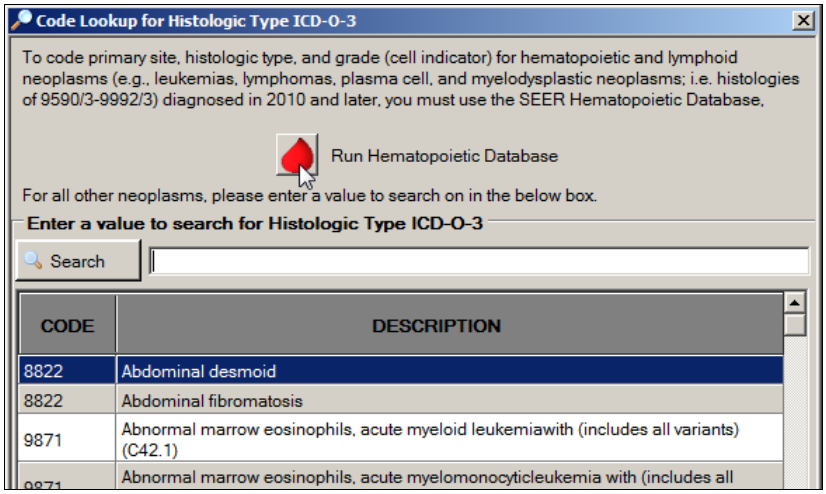


Once installed on the same computer on which Abstract Plus is installed, the Hematopoietic Database is minimally integrated into Abstract Plus, and can be launched in the following three ways.

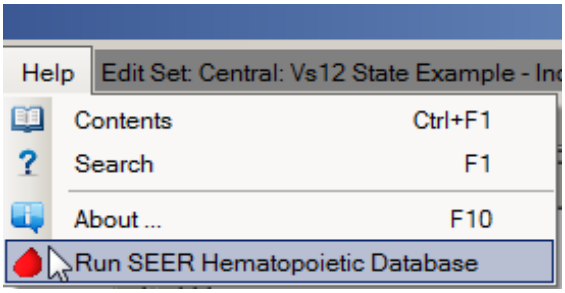
i. **From the Histology Lookup window**: **Click** on the **magnifying glass icon** to the left of the Histologic Type ICD-O-3 data item or **press F4** to use the search feature.



Then **click** the **blood drop icon** to launch the Hematopoietic database.



ii. Click on the **Help** menu, and select **Run SEER Hematopoietic Database**.



iii. Click the Hematopoietic Database icon on the tool bar  .

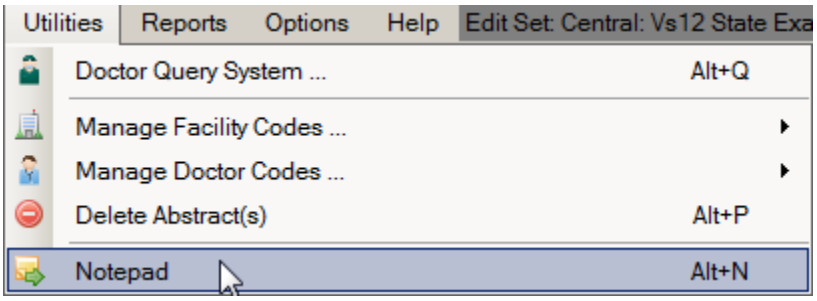
Be sure to follow the steps in the flowchart in Appendix B when using the Hematopoietic Database and Manual to code hematopoietic and lymphoid neoplasms.

Using the Notepad Function

The Notepad function is integrated into Abstract Plus under the Utilities menu. The Notepad allows you to view the contents of a file using the Notepad function without having to navigate away from Abstract Plus.

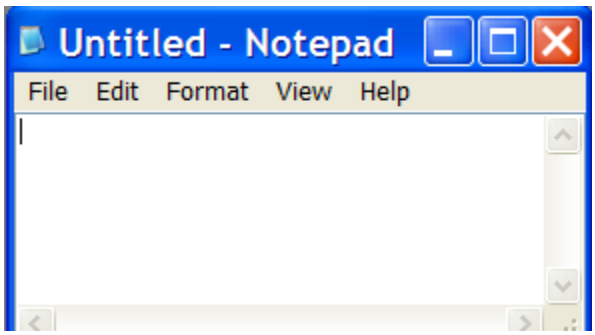
To use the Notepad function, complete these steps.

1. The Notepad function can be opened in two ways.
   a. Click on the **Utilities** menu, and select **Notepad**.



   b. Use the keystroke **Alt+N**.

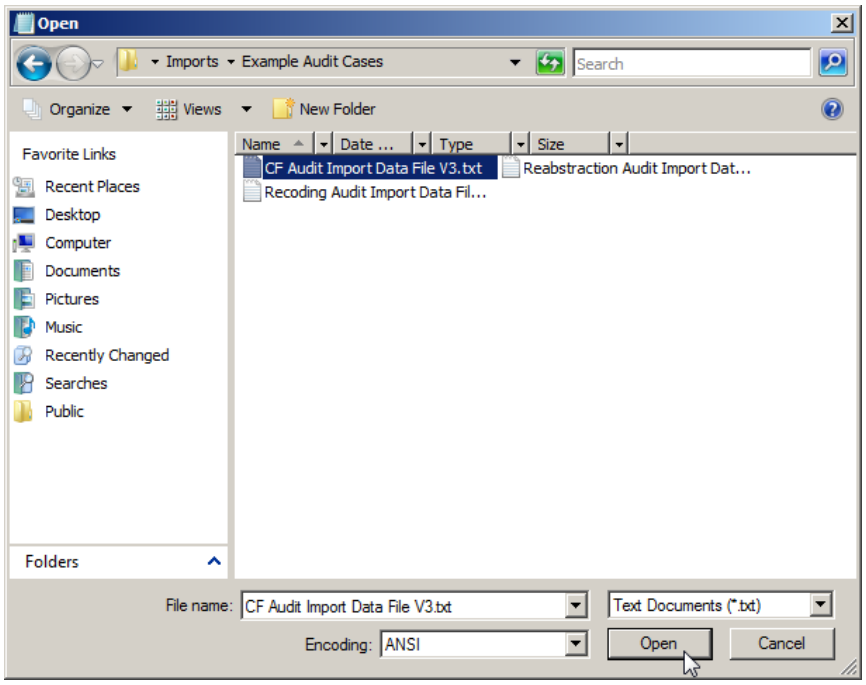
   Result: **Notepad** opens.



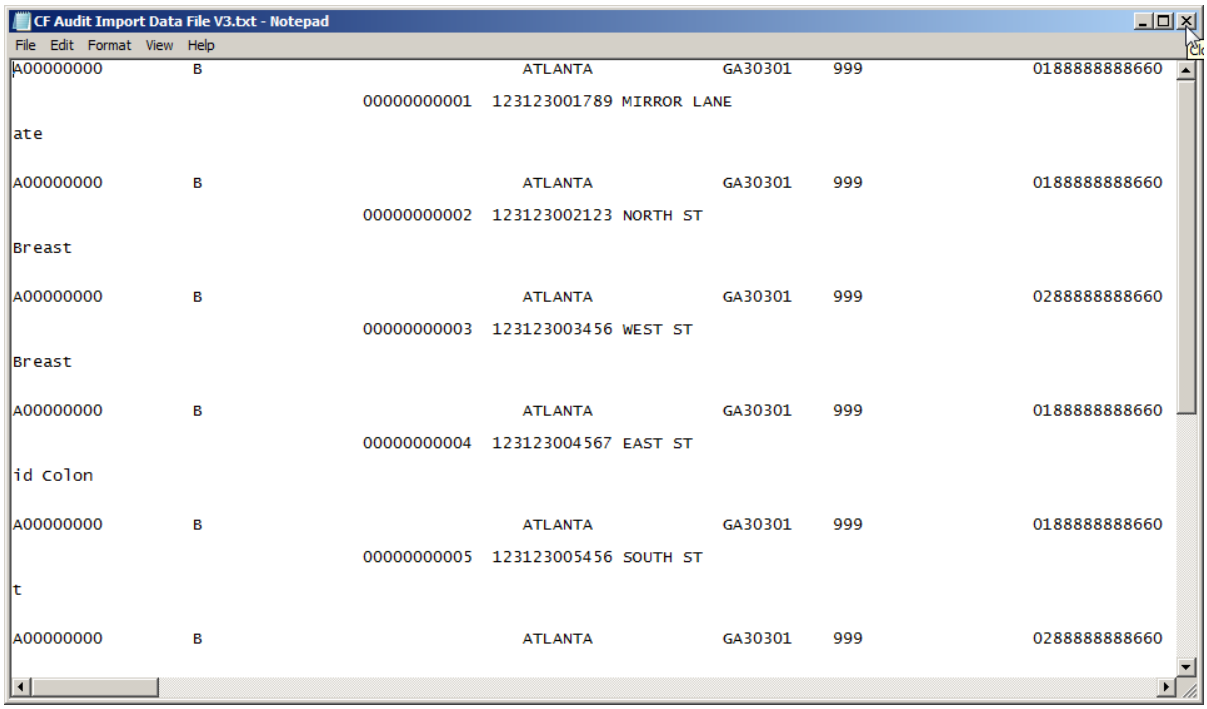
2. Click **File** on the Notepad menu and select **Open**.

   Result: An Open file windows dialog box opens.

3. Navigate to the folder and text file that you would like to open, and click **Open**.



   Result: The selected file opens in Notepad.



4. When you are done viewing the contents of the file, **close** Notepad.

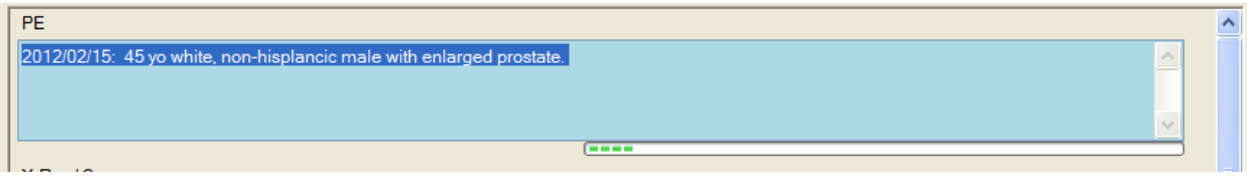
Entering Information into Text Fields

The NAACCR Volume II Data Dictionary defines text documentation as an essential component of a complete electronic abstract. Text information is utilized for quality control and special studies, and is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process and treatments provided should be entered manually from the medical record. It is best practice to abstract all available text information prior to entering codes for any of the coded cancer identification of treatment data items.

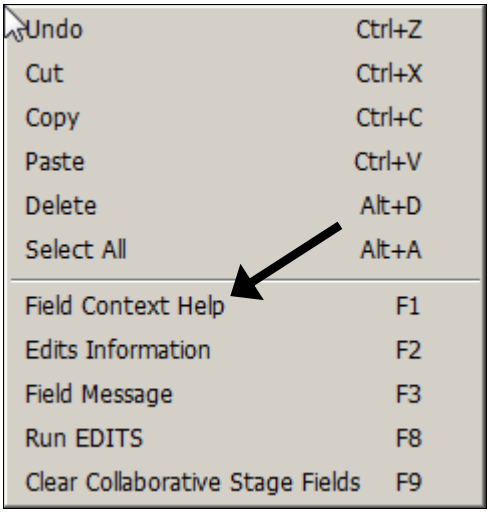
In Abstract Plus, the various text fields are presented within the data entry grid on the right side of the Abstracting Window. The order and names of the text fields that you see is specified by your Abstract Plus Administrator upon set up of the software.

You can scroll up and down in the text entry grid separate from the data entry grid on the left, facilitating the concurrent viewing of text and codes. Note that when entering text, a helpful progress bar is displayed below each text field that indicates how much space is left so that you can properly prioritize the information you are entering.

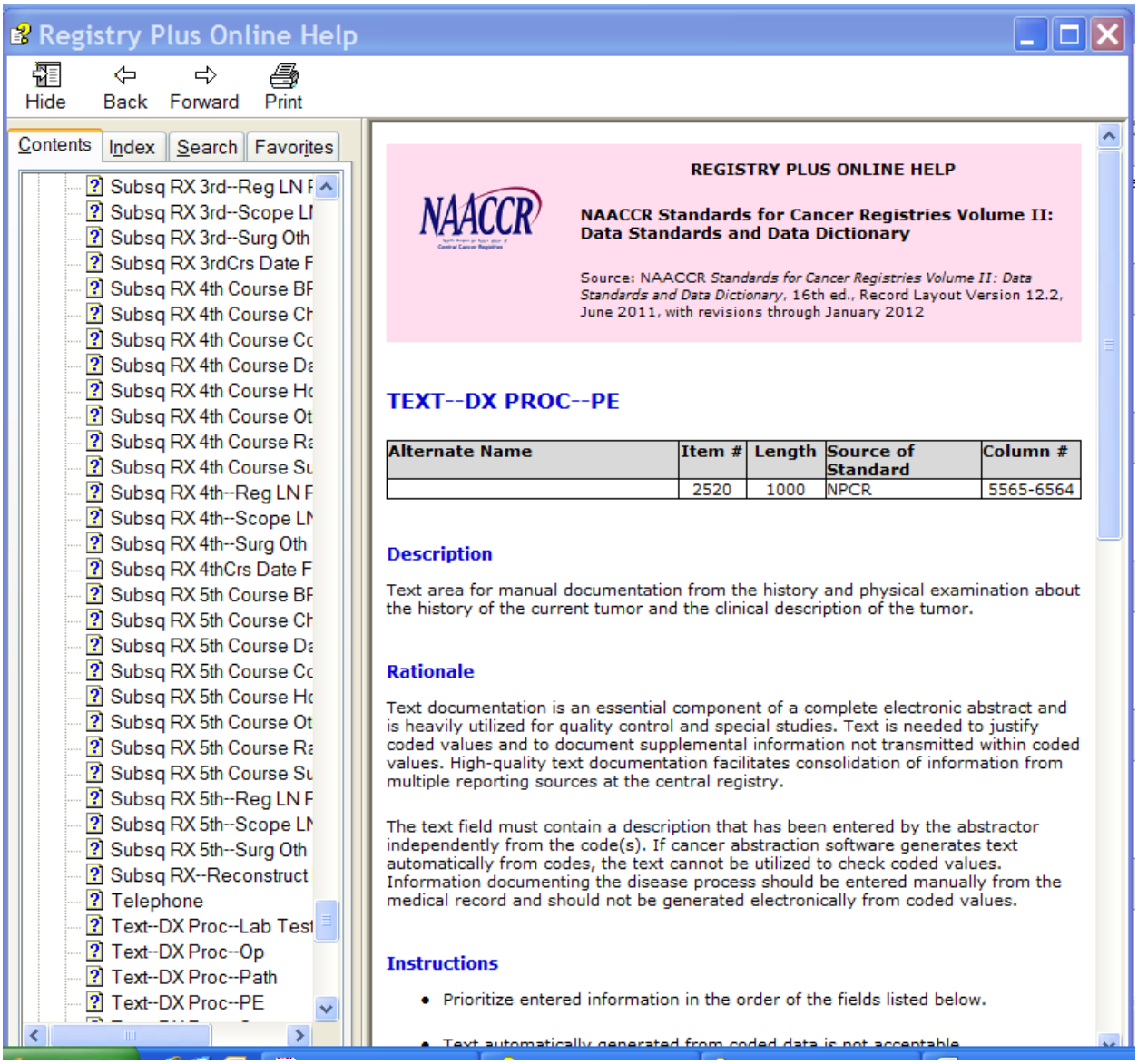


Line returns are not allowed in Abstract Plus text fields. Pressing Enter will move the cursor to the next text field in the text entry grid.

a. To access the Field Context Help for Text, use the **right-click function** in the text box, and select **Field Context Help**



Result: The Registry Plus Online Help window opens.



b. To **close Registry Plus Online** Help, click on the **X** in the upper right hand corner of the Registry Plus Online Help window.

Chapter 4: Working With Abstracts

Learning Objectives

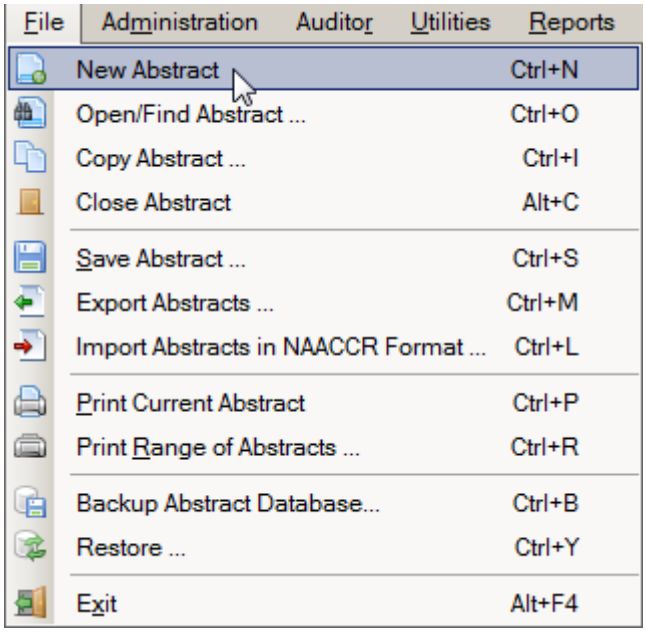
In this chapter, you will learn:

- To create a new abstract
- To familiarize yourself with the data entry procedure
- How to save an abstract
- To recognize data quality edits and error resolution features
- How to correct edit errors
- To complete and close an abstract
- How to modify an abstract, including entering text, coding histologic type, and deriving Collaborative Staging fields
- To copy an abstract

Creating a New Abstract

To create a new abstract, complete these steps.

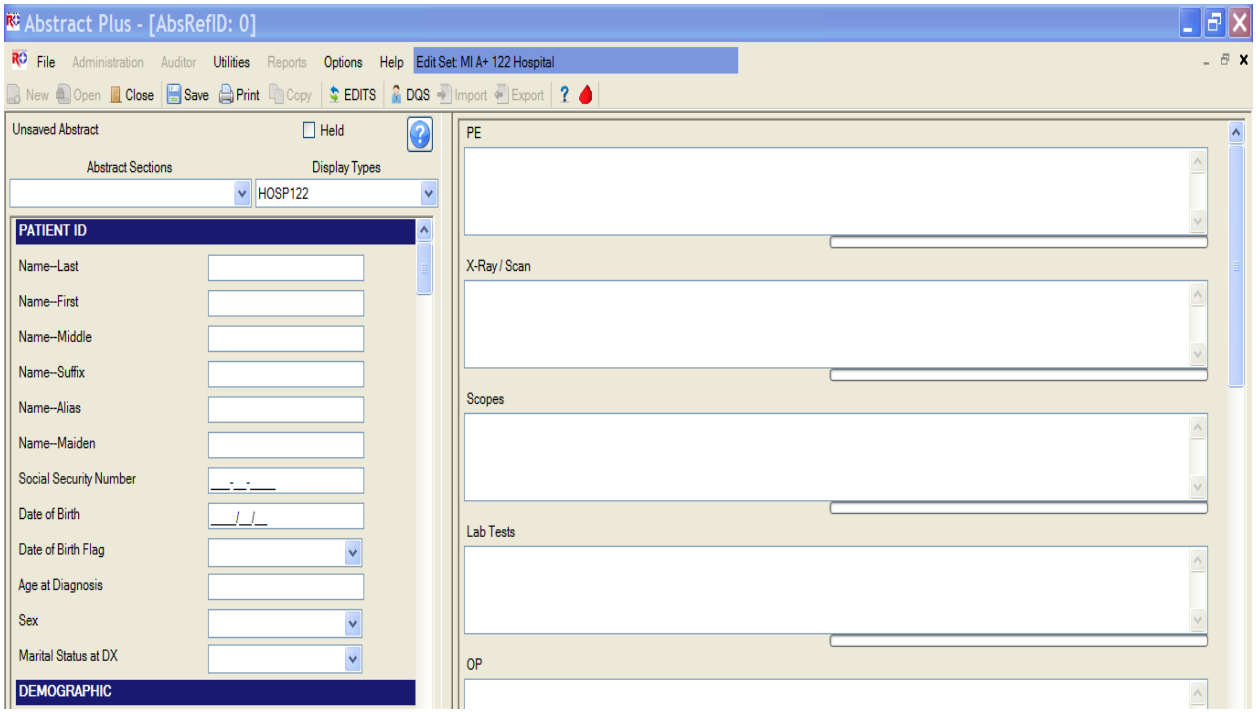
1. Open the Abstract Plus Abstracting window. This can be done in three ways.
    a. Click on the **File** menu and select **New Abstract**.



    b. Click the New icon on the tool bar 

.
    c. Use the keystroke **Ctrl+N**.

Result: The **Abstract Plus Abstracting Window** opens.



Data Entry Procedure

The following are data entry instructions for each data item. Instructions are for both HOSP122 and LAB122 Display Types. Press **Enter** after each data item is entered to move to the next data item/field.

If you are not familiar with the window and features of Abstract Plus version 3.2.1.0, go to Chapter 3 first.

Note

Line returns are not allowed in Abstract Plus text fields---pressing Enter will move the cursor to the next text field in the text entry grid.

Tip

If you begin typing in the data item, but find you need to revise what you have typed, press the backspace key to delete what you have already entered, and start typing again. This enables the find-as-you-type feature to automatically find your revised entry.

Important

The Item No. corresponds to the Item Number on the MCSP Cancer Report Form; however, not all Fields have a MCSP Item Number. The order of the Data Item and Value to be Entered is provided below in the **display field order in Abstract Plus version 3.2.1.0** (not the numerical order on the **Cancer Report Form**).

ENTERING PATIENT ID INFORMATION

Item No.	Data Item/Field	Value to be Entered
1a.	**Name-Last:**	Type the legal Last Name of the patient. Truncate name if more than 40 letters long. Blanks, spaces, hyphens, and apostrophes are allowed. If the last name is not available, type Unknown. This field may be updated, if the last name changes. For information on how to submit corrections, refer to 'Submitting Corrections' in the *MCSP Cancer Reporting Manual*. ***Do not leave this data item blank.***
1b.	**Name-First:**	Type the legal First Name of the patient. Truncate if more than 40 letters long. Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation. If the patient's first name is not available, type Unknown. This field may be updated, if the first name changes. For information on how to submit corrections, refer to 'Submitting Corrections' in the *MCSP Cancer Reporting Manual*. ***Do not leave this data item blank.***
1c.	**Name-Middle:**	Type the legal Middle Name or Middle Initial of the patient. Blanks, spaces, hyphens, and apostrophes are allowed. Do not use other punctuation. For information on how to submit corrections, refer to 'Submitting Corrections' in the *MCSP Cancer Reporting Manual*. If no middle name or initial, press **Enter** to move to the next field.
	Name-Suffix	Type the suffix (title) that follows the patient's last name, such as a generation or credential status (e.g., MD, III, Sr., Jr.).

Item No.	Data Item/Field	Value to be Entered
		If unknown or not reporting, press **Enter** to move to the next field.
3.	**Name-Alias:**	Type the alternate name or "AKA" (also known as) used by the patient. Note that maiden name is entered in Name-Maiden. If unknown or not reporting, press **Enter** to move to the next field.
2.	**Name-Maiden:**	Type the Maiden Name of female patients who are or have been married. Do not abbreviate. If unknown or not reporting, press **Enter** to move to the next field**.**
4.	**Social Security Number:**	Type the patient's Social Security Number without dashes and without any letter suffix. A patient's Medicare claim number may not always be identical to the patient's social security number. Code Social Security Numbers that end with "B" or "D" as 999999999. (The patient receives benefits under the spouse's number and this is the spouse's Social Security Number.) If the patient does not have a social security number, type 999999999. If the patient's Social Security Number is not available, type 999999999. *NOTE:* Social Security Number is a **required** data item regardless of facility type. If after review of the patient's hospital charts, outpatient records, other available records, other facility inquiries, or follow-back with the physician on record, the social security number is unknown, type 999999999. ***Do not leave this data item blank.***
7.	**Date of Birth:**	Type the patient's Date of Birth as indicated in the patient record in YYYYMMDD format. For *in utero* diagnosis and treatment, record the

Item No.	Data Item/Field	Value to be Entered
		actual date of birth. It will follow one or both dates for these events. If age at diagnosis and year of diagnosis are known, but year of birth is unknown, then year of birth should be calculated and so coded. Estimate date of birth when information is not available. It is better to estimate than to leave birthdate unknown. If the date of birth cannot be determined at all, leave this data item blank and record the reason in the Date of Birth Flag.
	Date of Birth Flag:	The Date of Birth Flag explains why there is no appropriate value in the corresponding Date of Birth field. Type 12 if the Date of Birth cannot be determined at all. Or double click on the appropriate code in the pull-down list. Leave this data item blank if Date of Birth has a full or partial date recorded.
	Age at Diagnosis:	Leave Age at Diagnosis field **blank** and press **Enter**. Age at Diagnosis will be automatically calculated and entered when the Date of Birth and Date of Diagnosis values are entered. *NOTE:* Different tumors for the same patient may have different values.
9.	**Sex:**	Type the Sex code as indicated in the patient record. Or double click on the appropriate code in the pull-down list. *NOTE:* The same sex code should appear in each abstract for a patient with multiple tumors.

Item No.	Data Item/Field	Value to be Entered
		Do not leave this data item blank.
12.	**Marital Status at DX:**	Type the Marital Status at DX code as indicated in the patient record at the time of diagnosis. Or double click on the appropriate code in the pull-down list. *NOTE:* If the patient has multiple tumors, the Marital Status at DX may be different for each tumor. If unknown or not reporting, type 9. ***Do not leave this data item blank.***

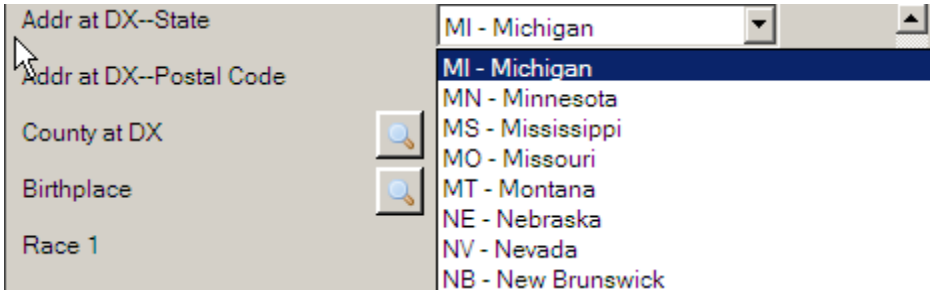
ENTERING DEMOGRAPHIC INFORMATION

Item No.	Data Item/Field	Value to be Entered
5a.	**Addr at Dx-No Street:**	Type the Number and Street address or the rural mailing address of the patient's usual residence **at the time the reportable tumor was diagnosed**. The address should be fully spelled out with standardized use of abbreviations and punctuation per U.S Postal Service postal addressing standards. Punctuation limited to: . / - # These standards are referenced in USPS Publication 28, July 2008, *Postal Addressing Standards*. The current USPS Pub. 28 may be found and downloaded from the following Web Site: http://pe.usps.gov/cpim/ftp/pubs/Pub28/pub28.pdf. Canadian addresses should conform to the *Canada Postal Guide*, last updated January, 2010. The current Canadian Postal Address standards may be found at the following website: http://www.canadapost.ca/tools/pg/manual/default-e.asp Additional address information such as facility,

Item No.	Data Item/Field	Value to be Entered
		nursing home, or name of apartment complex should be entered in Address at Diagnosis Supplemental field (Addr At DX – Supplementl). *NOTE:* If the patient has multiple tumors, the address may be different for subsequent primaries. Do **not** update this data item if the patient's address changes. If the address is unknown, type "Unknown." ***Do not leave this data item blank.***
5c.	**Addr at DX-Supplementl:**	Type the place or facility (e.g., a nursing home or name of an apartment complex) of the patient's usual residence **at the time the reportable tumor was diagnosed**. Do **not** update this data item if the patient's address changes. If not applicable or unknown, leave this data item blank and press **Enter**.
5b.	**Addr at DX-City:**	Type the City or Town in which the patient resides **at the time the reportable tumor was diagnosed**. *NOTE:* If the patient has multiple tumors, the city or town may be different for subsequent primaries. Do **not** update this data item if the patient's address changes. ***Do not leave this data item blank.***
5d.	**Addr at DX-State:**	Begin by typing the U.S. Postal abbreviation for the state, territory, commonwealth, U.S. possession, or Canadian province or territory in which the patient resides **at the time the reportable tumor was diagnosed**. Notice that the system displays the full name of the state in the pull-down list even before you finish typing. Press **Enter.**

Item No.	Data Item/Field	Value to be Entered
		If the residence is unknown, press the backspace key to delete the default value of MI - Michigan. Type Z and select ZZ – Residence Unknown and, press **Enter**. *NOTE:* If the patient has multiple tumors, the state of residence may be different for each tumor. ***Do not leave this data item blank.***

Example: Start typing **Michigan.** Notice that the system displays the full name of the state in the pull-down list even before you finish typing. Press **Enter.**



Tip

If you begin typing in the data item, but find you need to revise what you have typed, press the backspace key to delete what you have already entered, and start typing again. This enables the find-as-you-type feature to automatically find your revised entry.

5e.	**Addr at DX-Postal Code:**	Type the patient's extended Postal Code at the time of diagnosis and treatment. If the extended zip code is not available, type the five-digit zip code. (Blanks follow the 5-digit code). For Canadian residents, record the six-character postal code. When available, record the postal code for other countries. Not US, not Canada, postal code unknown, type 888888888.

Item No.	Data Item/Field	Value to be Entered
		US/Canada, postal code unknown; OR residence unknown, type 999999999. If the patient has multiple tumors, the postal code may be different for subsequent primaries. Do **not** update this data item if the patient's postal code changes. ***Do not leave this data item blank.***
6.	**County at DX:**	To display a searchable list of possible values, **click** the **magnifying glass icon** next to the field. Enter a value to search for County at Diagnosis in the search box. Double click on the appropriate County at Diagnosis code. If unknown county, type 999. If Out-of-State county is not available, Non-US resident, type 999. *NOTE:* Code 998 is **not** an allowable value in Abstract Plus Version 3.2.1.0. If county code not known AND a resident outside of the state of the reporting institution, use code 999. ***Do not leave this data item blank.***
8.	**Birthplace:**	To display a searchable list of possible values, **click** the **magnifying glass icon** next to the field, or press the **F4** key and a Lookup window will appear. Type the name of the birthplace in the search box. Double click on the appropriate code or highlight and press **Enter**. You may need to use the scroll bar to display additional values. Use the SEER Geocodes for "Place of Birth." These codes include states of the United States as well as foreign countries. For SEER Geocodes, see the most recent *Standards for Cancer Registries Volume II: Data Standards and Data Dictionary* at

Item No.	Data Item/Field	Value to be Entered
		http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx If unknown or not reporting, leave the preset default code of 999 and press **Enter.** ***Do not leave this data blank.***
11.	**Race 1:**	Type the Race code according to the documentation in the patient's medical record. Or double click on the appropriate code in the pull-down list. You may need to use the scroll bar to display additional values. *NOTE:* **Race** is a **required** data item regardless of facility type. If the race is not documented in the patient's medical record, outpatient records, other available records; such as laboratory specimen form, inquiries with other facilities or the physician on record **must** be conducted to obtain this information. ***Do not leave this data blank.***
	Race 2: **Race 3:** **Race 4:** **Race 5:**	If the patient is multi-racial, code all races using *Race 2* through *Race 5*. If no further race is documented, record race as 88. ***Do not leave these data items blank.***
10.	**Spanish/Hispanic Origin:**	Type the Spanish/Hispanic Origin code. Or double click on the appropriate code in the pull-down list. You may need to use the scroll bar to display additional values. ***Do not leave this data blank.***

ENTERING HOSPITAL SPECIFIC INFORMATION

Item No.	Data Item/Field	Value to be Entered
19.	**Medical Record Number:**	Type the number that represents the patient's permanent Medical Record Number at the reporting facility.

Item No.	Data Item/Field	Value to be Entered
		If the number is unknown, type Unknown. If not reporting (Independent Laboratory), leave the default value of Unknown and press **Enter**. ***Do not leave this data item blank.***
20.	**M17 Laboratory Number:**	Type the number that represents the patient's Laboratory Number at the reporting facility. If unknown, type Unknown. If not reporting, leave the default value of Unknown and press **Enter**. ***Do not leave this data item blank.***
24.	**Reporting Facility:**	Type the number of the Reporting Facility. Or to display a searchable list of possible values, **click** the **magnifying glass icon** next to the field, or press the **F4** key and a Lookup window will appear. In the search box, type the state name and city followed by the facility name. Double click on the appropriate facility number or highlight and press **Enter**. You may need to use the scroll bar to display additional values. ***Do not leave this data item blank.***
22.	**Type of Reporting Source:**	Type the Reporting Source code. Or double click on the appropriate code in the pull-down list. ***Do not leave this data item blank.*** *NOTE:* For LAB122 Display Type, the next required data item is Class of Case.
29.	**Date of 1st Contact:**	Type the date the patient first had contact with the facility as either an inpatient or outpatient for diagnosis and/or first course of treatment for this reportable tumor.

Item No.	Data Item/Field	Value to be Entered
		The date may be the date of an outpatient visit for a biopsy, X-ray, or laboratory test, or the date a pathology specimen was collected at the hospital. For analytic cases (Class of Case 00-22), the Date of First Contact is the date the patient (case) became analytic. For non-analytic cases, it is the date the patient first qualified for the Class of Case that causes the case to be abstracted. When a patient is diagnosed in a staff physician's office, the date of first contact is the date the patient was physically first seen at the reporting facility. If this is an autopsy-only or death certificate-only case, then use the date of death. ***Do not leave any part of this data item blank.***
	Date of 1st Contact Flag:	With a valid date entered for the Date of First Contact, the Date of First Contact Flag field MUST be BLANK.
27a.	**Date of Inpatient Adm:**	Type the date of the Inpatient Admission to the reporting facility for the most definitive surgery in the YYYYMMDD format. In the absence of surgery, use date of inpatient admission for any other cancer-directed therapy. In the absence of cancer-directed therapy, use date of inpatient admission for diagnostic evaluation. If unknown or not applicable, leave this data item blank and press **Enter**.
27b.	**Date of Inpt Adm Flag:**	Type the code that explains why there is not an appropriate value in the corresponding Date of Inpatient Admission field. Or double click on the appropriate code in the pull-down list.

Item No.	Data Item/Field	Value to be Entered
		Leave this data item blank if there is a full or partial date in the Date of Inpatient Admission field.
28a.	**Date of Inpatient Disch:**	Type the Date of Inpatient Discharge from the facility after the most recent definitive surgery in the YYYYMMDD format. In the absence of surgery, use date of inpatient discharge for other cancer-directed therapy. In the absence of cancer-directed therapy, use the date of inpatient discharge for diagnostic evaluation. This discharge date corresponds to the admission date described in the Inpatient Admission Date field. If unknown or not applicable, leave this data item blank and press **Enter.**
28b.	**Date of Inpt Disch Flag:**	Type the code that explains why there is not an appropriate value in the corresponding Date of Inpatient Discharge field. Or double click on the appropriate code in the pull-down list. Leave this data item blank if there is full or partial date in the Date of Inpatient Discharge field.
26.	**Class of Case:**	Type the Class of Case code. Or double click on the appropriate code in the pull-down list. *NOTE:* **Class of Case** is a **required** data item regardless of facility type. ***Do not leave this data item blank.***
21.	**Accession Number-Hosp:**	The Accession Number is ONLY required for Hospitals with a Registry, in which case, the number would be assigned as the patient is enrolled into the system. The first four numbers specify the year and the last five numbers are the numeric order in which the patient was entered into the registry database.

Item No.	Data Item/Field	Value to be Entered
		If reporting, type the Hospital Accession Number (4-digit year followed by the 5-digit accession number.) There cannot be any blanks in the middle of the accession number. When a patient is deleted from the database, do not reuse the accession number for another patient. Numeric gaps are allowed in accession numbers**. (**A patient's accession number is never reassigned.) If not reporting, leave the preset default code and press **Enter.**
21.	**Sequence Number-Hosp:**	Type the Sequence Number. (You cannot double click on the Allowable Values in the pull-down list.) Codes 00-59 and 99 indicate reportable neoplasms of *in situ* or malignant behavior (*Behavior Code ICD-O-3* equals 2 or 3). Codes 60-88 indicate neoplasms of non-malignant behavior (*Behavior Code ICD-O-3* equals 0 or 1). Code 00 only if the patient has a single malignant primary. If the patient develops a subsequent malignant or *in situ* primary tumor, change the code for the first tumor from 00 to 01, and number subsequent tumors sequentially. Code 60 only if the patient has a single non-malignant primary. If the patient develops a subsequent non-malignant primary, change the code for the first tumor from 60 to 61, and assign codes to subsequent non-malignant primaries sequentially. If not reporting, the sequence number for unspecified number of **non-malignant tumor** is recorded as 88. If not reporting, the sequence number for unspecified number of **malignant tumor, or unknown** is recorded as 99.

Item No.	Data Item/Field	Value to be Entered ***Do not leave this data item blank.***
13.	**Primary Payer at DX:**	Type the Primary Payer at Diagnosis code at the time of diagnosis if the patient is diagnosed at the reporting facility. If the patient is diagnosed elsewhere or the payer at the time of diagnosis is not known record the payer when the patient is initially admitted for treatment. Record the type of insurance reported on the patient's admission page. Codes 21 and 65–68 are to be used for patients diagnosed on or after January 1, 2006. If more than one payer or insurance carrier is listed on the patient's admission page record the first. If the patient's payer or insurance carrier changes, do not change the initially recorded code. If the Insurance status is unknown or not reporting, type 99. ***Do not leave this data item blank.***
106.	**Abstracted By:**	When you log into Abstract Plus, your alphanumeric code assigned by the reporting facility at the time of creating a User Account will automatically be displayed in the Abstracted By field. Press **Enter** to move to the next field.

ENTERING HOSPITAL CONFIDENTIAL INFORMATION

Item No.	Data Item/Field	Value to be Entered
15a.	**Text-Usual Occupation:**	Type the Usual Occupation of the patient. "Usual Occupation" is the kind of work performed during most of the patient's working life before diagnosis of this cancer/reportable condition. If the Usual Occupation is not available or is unknown, record the patient's current or most recent

Item No.	Data Item/Field	Value to be Entered
		occupation, or any available occupation. Do **not** include descriptive terms with the Usual Occupation such as "longest," "current," "last 10 years," etc. Do **not** record "retired." For further information, refer to *A Cancer Registrar's Guide to Collecting Industry and Occupation* to assist with coding this data item. The guide can be downloaded at http://www.cdc.gov/niosh/docs/2011-173/ and has been provided by CDC. If no information is available, or not reporting, type Unknown. ***Do not leave this data item blank.***
15b.	**Text-Usual Industry:**	Type the Usual Industry of the patient. Record the primary type of activity carried on by the business/industry at the location where the patient was employed for the most number of years before diagnosis of this tumor. Be sure to distinguish among "manufacturing," "wholesale," "retail," and "service" components of an industry that performs more than one of these components. If the primary activity carried on at the location where the patient worked is unknown, but the name of the company is known, type the company name along with the city or town in which the patient performed his/her Usual Industry. Do **not** record "retired." For further information, refer to *A Cancer Registrar's Guide to Collecting Industry and Occupation* to assist with coding this data item. The guide can be downloaded at http://www.cdc.gov/niosh/docs/2011-173/ and has been provided by CDC.

Item No.	Data Item/Field	Value to be Entered
		If no information is available or not reporting, type Unknown. ***Do not leave this data item blank.***
16a-c.	**MI20 Family Hist Cancer:**	Type whether or not the patient has a Family History of Cancer by using the pull-down list provided.

There is no Field Context Help available in Abstract Plus for Family History of Cancer.

The user defined codes for Family History of Cancer have been established by the MCSP. To assist with coding MI20 Family History of Cancer the user defined codes and descriptions are as follows:

Code	Description
0	Family hx=no, immediate=no, same site=no
1	Family hx=yes, immediate=yes, same site=yes
2	Family hx=yes, immediate=yes, same site=no
3	Family hx=yes, immediate=no, same site=yes
4	Family hx=yes, immediate=no, same site=no
5	Family hx=yes, immediate=yes, same site=blank
6	Family hx=yes, immediate=blank, same site=yes
7	Family hx=yes, immediate=blank, same site=no
8	Family hx=yes, immediate=blank, same site=blank
9	Family hx=blank, immediate=blank, same site=blank
A	Family hx=yes, immediate=no, same site=blank

If unknown or not reporting, type 9.

Do not leave this data item blank.

17.	**MI21 Alcohol History:**	Type whether or not the patient has a History of Alcohol Use by using the pull-down list provided.

There is no Field Context Help available in Abstract Plus for Alcohol History.

The user defined codes for Alcohol History have been established by the MCSP. To assist with coding the MI21 Alcohol History the user defined codes and descriptions are as follows:

Item No.	Data Item/Field	Value to be Entered

Code	Description
1	Current=checked, prior=blank, never=blank
2	Current=blank, prior=checked, never=blank
3	Current=blank, prior=blank, never=checked
9	Current=blank, prior=blank, never=blank

If unknown or not reporting, type 9.

Do not leave this data item blank.

18. **MI22 Tobacco History:** Type whether or not the patient has a History of Tobacco Use by using the pull-down list provided.

There is no Field Context Help available in Abstract Plus for Tobacco History.

The user defined codes for Tobacco History have been established by the MCSP. To assist with coding MI22 Tobacco History the user defined codes and descriptions are as follows:

Code	Description
1	Current=checked, prior=blank, never=blank
2	Current=blank, prior=checked, never=blank
3	Current=blank, prior=blank, never=checked
9	Current=blank, prior=blank, never=blank

If unknown or not reporting, type 9.

Do not leave this data item blank.

ENTERING CANCER IDENTIFICATION INFORMATION

Item No.	Data Item/Field	Value to be Entered
23.	**Casefinding Source:**	Type the Casefinding Source code. This data item codes the type of source through which the tumor was first identified at the reporting facility. Or double click on the appropriate code in the pull-down list. You may need to use the scroll bar to display additional values. ***Do not leave this data item blank.***

Item No.	Data Item/Field	Value to be Entered
30.	**Date of Diagnosis:**	Type the Date of Diagnosis in the YYYYMMDD format. Record the date of initial diagnosis by a recognized medical practitioner for the tumor being reported whether clinically or microscopically confirmed. If the year is unknown, estimate the diagnosis year based upon documentation in the medical record and how long the patient has had the diagnosis. If the month is unknown, use the month of **July (7)** for the month of diagnosis. If the day is unknown, use the **fifteenth (15)** for the day of diagnosis. ***Do not leave any part of this data item blank.***
	Date of Diagnosis Flag:	With a valid date entered for the Date of Diagnosis, the Date of Diagnosis Flag field MUST be BLANK.
31.	**Primary Site:**	Type the 4-digit ICD-O-3 topography code for the primary site being reported. To view a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. In the search box, type the name of the primary site being reported (e.g., if reporting a lung primary type **lung**). Double click on the appropriate site or highlight and press **Enter**. You may need to use the scroll bar to display additional values. To launch the SEER Hematopoietic Database (DB), which is used to determine the Primary Site, Histologic Type and Grade for all Hematopoietic and Lymphoid Neoplasm **9590/3-9992/3** (e.g., leukemia, lymphoma, myelodypsplastic neoplasms), **click** the **blood drop** icon in the Lookup Window, or the **blood-drop icon** on the menu bar. ***Do not leave this data item blank.***

Item No.	Data Item/Field	Value to be Entered
32.	**Laterality:**	Type the Laterality code. Laterality refers to a specific side of the body or lobe of an organ. In the case of paired or bilateral organs, it is important to indicate whether the primary site of the tumor is the right organ, the left organ, or bilateral involvement. Or double click on the appropriate code in the pull-down list. If the organ is **not** a paired site, type 0. ***Do not leave this data item blank.***
37.	**Lymph-vascular Invasion:**	Type the code to indicate whether lymph vascular invasion (LVI) is identified in the pathology report. This field records the absence or presence of tumor cells in lymphatic channels (not lymph nodes) or blood vessels within the primary tumor as noted microscopically by the pathologist. Or double click on the appropriate code in the pull-down list. For more information on LVI, refer to the current CS Manual (v02.04) at http://www.cancerstaging.org/cstage/manuals/index.html. ***Do not leave this data item blank.***
33a.	**Histologic Type ICD-O-3:**	Type the 4-digit ICD-O morphology code for the histologic type of the tumor being reported. Use the *International Classification of Diseases for Oncology, Third Edition (ICD-O-3)* coding book to assign the histology or morphology code for **Solid Tumors**. *Example:* 8140 = adenocarcinoma, NOS. Use the current *Multiple Primary and Histology Coding Rules Manual* when coding the histology for all reportable **Solid Tumors**. These rules are ***effective for cases diagnosed January 1, 2007, or***

Item No.	Data Item/Field	Value to be Entered
		later. Do **not** use these rules to abstract cases diagnosed prior to January 1, 2007. For lymphoma, leukemia and other hematopoietic tumors (**Non-Solid Tumors**), follow the instructions in the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding* Manual, which has been installed and is run as a separate application on your computer. Or to view a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. • To code the histologic type for hematopoietic and lymphoid neoplasms diagnosed 2010 and later, **click** on the **blood-drop icon** to run the Hematopoietic Database. • For all other neoplasms, in the search box, type the name of the histologic type of tumor being reported (e.g., for adenocarcinoma arising in an adenomatous polyp, type adenocarcinoma in adenomatous polyp). Double click on the appropriate histologic type or highlight and press **Enter**. You may need to use the scroll bar to display additional values. ***Do not leave this data item blank.***
33b.	**Behavior Code ICD-O-3:**	Type the Behavior code. Or double click on the appropriate code in the pull-down list. ***Do not leave this data item blank.***
34.	**Grade:**	Type the code for the grade or degree of differentiation of the primary tumor being reported. Or double click on the appropriate code in the pull-down list. ***Hematopoietic and Lymphoid Neoplasms:*** For cases ***diagnosed January 1, 2010 and forward***,

Item No.	Data Item/Field	Value to be Entered
		refer to the Grade of Tumor Rules in the *Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual*, which is embedded in the SEER Hematopoietic Database. To open the DB, **click** on the **blood-drop icon** on the menu bar. *NOTE:* Do **not** use the WHO grade to code this data item. ***Do not leave this data item blank.***
36.	**Grade Path Value:**	This field documents the numerator or first number of a tumor grade reported in a 2, 3, or 4 grade system. The Grade Path Value supplements but does not replace the field Grade/Differentiation, which is part of the ICD-O-3 morphology code structure and may be converted from another grading system or coded by a different set of rules. Grade Path Value is paired with Grade Path System to describe the original grade of the tumor. Refer to http://www.cancerstaging.org/cstage/manuals/coding0204.html for further information on Grade Path Value. ***If not applicable, leave this data item blank.***
35.	**Grade Path System:**	This field documents the denominator or second number of a tumor grade reported in a 2, 3, or 4 grade system. The Grade Path System field supplements but does not replace the field Grade/Differentiation, which is part of the ICD-O-3 morphology code structure and may be converted from another grading system or coded by a different set of rules. Grade Path System is paired with Grade Path Value to describe the original grade of the tumor.

Item No.	Data Item/Field	Value to be Entered
		Refer to http://www.cancerstaging.org/cstage/manuals/coding0204.html for further information on Grade Path System. ***If not applicable, leave this data item blank.***
38.	**Diagnostic Confirmation:**	Type the Diagnostic Confirmation code. (This field records the best method of diagnostic confirmation of the cancer being reported at any time in the patient's history.) Or double click on the appropriate code in the pull-down list. ***Do not leave this data item blank.***

ENTERING STAGE/PROGNOSTIC FACTORS

Item No.	Data Item/Field	Value to be Entered
39.	**SEER Summary Stage 2000:**	Type the SEER Summary Stage code. ***Note:*** You must use the *SEER Summary Staging Manual - 2000, c*odes and coding instructions for ***cases diagnosed on or after January 1, 2001***. Download and print the manual from http://seer.cancer.gov/tools/ssm/ Summary stage should include all information available through completion of surgery (ies) in the ***first course of treatment or within 4 months of diagnosis in the absence of disease progression, whichever is longer.*** Or double click on the appropriate code in the pull-down list. ***Do not leave this data item blank.*** ***Note:*** For LAB122 Display Type, the next applicable coding field is CS Tumor Size.
40.	**TNM Clin T:**	Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known

Item No.	Data Item/Field	Value to be Entered
		prior to the start of any therapy. Valid 'Clinical T' codes are as follows: X 1B 3 0 1B1 3A A 1B2 3B IS 1C 3C ISPU 1D 3D ISPD 2 4 1M1 2A 4A 1MI 2A1 4B 1 2A2 4C 1A 2B 4D 1A1 2C 4E 1A2 2D 88 *NOTE:* **Blank** is **not** an allowable value in Abstract Plus version 3.2.1.0. If not applicable, no code assigned in current AJCC manual, type 88. If not recorded, type X. For further information, refer to the current *AJCC Cancer Staging Manual* for staging rules. ***Do not leave this data item blank.***
40. cont.	**TNM Clin N:**	Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known ***prior*** to the start of any therapy. Valid 'Clinical N' values are as follows: X 1C 0 2 0I- 2A 0I+ 2B 0M- 2C 0M+ 3 1M1 3A *(go to next page)*

Item No.	Data Item/Field	Value to be Entered
		0A 3B 0B 3C 1 4 1A 88 1B *NOTE:* **Blank** is **not** an allowable value in Abstract Plus Version 3.2.1.0. If not applicable, no code assigned in current AJCC manual, type 88. If not recorded, type X. For further information, refer to the current *AJCC Cancer Staging Manual* for staging rules. ***Do not leave this data item blank.***
40. cont.	**TNM Clin M:**	Identifies the presence or absence of distant metastasis (M) of the tumor known ***prior*** to the start of any therapy. Valid 'Clinical M' values are as follows: X (AJCC editions 1-6 ONLY) 0 0I+ 1 1A 1B 1C 1D 1E 88 If not applicable, no code assigned in current AJCC manual, type 88. If CS Mets at DX is recorded as '00 – None,' TNM Clinical M must be recorded as '0 – No distant metastasis. If unknown AND CS Mets at DX is not recorded as 00, type X.

Item No.	Data Item/Field	Value to be Entered
		NOTE: **Blank** is **not** an allowable value in Abstract Plus Version 3.2.1.0. For further information, refer to the current *AJCC Cancer Staging Manual* for staging rules. ***Do not leave this data item blank.***
40. cont.	**TNM Clin Stage Group:**	Identifies the anatomic extent of disease based on the T, N, and M elements known ***prior*** to the start of any therapy. Valid 'Clinical Stage Group' codes are as follows: 0, 0A, 0IS, 1, 1A, 1A1, 1A2, 1B, 1B1, 1B2, 1C, 1S, 2, 2A, 2A1, 2A2, 2B, 2C, 3, 3A, 3B, 3C, 3C1, 3C2, 4, 4A, 4A1, 4A2, 4B, 4C, OC, 88, 99 If not applicable, no code assigned in current AJCC manual, type 88. If not recorded, type 99. ***Do not leave this data item blank.***
40. cont.	**TNM Clin Descriptor:**	Identifies the AJCC clinical stage (prefix/suffix) descriptor of the tumor ***prior*** to the start of any therapy. Stage descriptors identify special cases that need separate analysis. The descriptors are adjuncts to and do not change the stage group. Valid 'Clinical Descriptor' codes are as follows:

Item No.	Data Item/Field	Value to be Entered
		0 None 1 E–Extranodal, lymphomas only 2 S–Spleen, lymphomas only 3 M–Multiple primary tumors in a single site 5 E&S–Extranodal and spleen, lymphomas only 9 Unknown; not stated in patient record Or double click on the appropriate code in the pull-down list. If there is no prefix or suffix descriptors that would be used for this case, type 0. If unknown, not stated, type 9. For further information, refer to the current *AJCC Cancer Staging Manual* for staging rules. ***Do not leave this data item blank.***
40.	**TNM Path T:**	Evaluates the primary tumor (T) and reflects the tumor size and/or extension of the tumor known ***following*** the completion of surgical therapy. Valid 'Pathological T' codes are as follows: X 1B1 3A 0 1B2 3B A 1C 3C IS 1D 3D ISPU 2 4 ISPD 2A 4A 1M1 2A1 4B 1 2A2 4C 1A 2B 4D 1A1 2C 4E 1A2 2D 88 1B 3 *NOTE:* **Blank** is **not** an allowable value in Abstract Plus Version 3.2.1.0. If not applicable, no code assigned in current AJCC manual, type 88.

Item No.	Data Item/Field	Value to be Entered
		If not recorded, type X. For further information, refer to the current *AJCC Cancer Staging Manual* for staging rules. ***Do not leave this data item blank.***
38. cont.	**TNM Path N:**	Identifies the absence or presence of regional lymph node (N) metastasis and describes the extent of regional lymph node metastasis of the tumor known ***following*** the completion of surgical therapy. Valid 'Pathological N' values are as follows: X, 0, 0I-, 0I+, 0M-, 0M+, 1M1, 0A, 0B, 1, 1A, 1B, 1C, 2, 2A, 2B, 2C, 3, 3A, 3B, 3C, 4, 88 *NOTE:* **Blank** is **<u>not</u>** an allowable value in Abstract Plus Version 3.2.1.0. If not applicable, no code assigned in current AJCC manual, type 88. If not recorded, type X. For further information, refer to the current *AJCC Cancer Staging Manual* for staging rules. ***Do not leave this data item blank.***
40. cont.	**TNM Path M:**	Identifies the presence or absence of distant metastasis (M) of the tumor known ***following*** the completion of surgical therapy. Valid 'Pathological M' values are as follows:

Item No.	Data Item/Field	Value to be Entered
		X (AJCC editions 1-6 ONLY) Blank 0 1 1A 1B 1C 1D 1E 88 If not applicable, no code assigned in current AJCC manual, type 88. For further information, refer to the current *AJCC Cancer Staging Manual* for staging rules. If unknown, not documented, leave blank.
40. cont.	**TNM Path Stage Group:**	Identifies the anatomic extent of disease based on the T, N, and M elements known ***following*** the completion of surgical therapy. Valid 'Path Stage Group' codes are as follows: 0 1S 3C1 0A 2 3C2 0IS 2A 4 1 2A1 4A 1A 2A2 4A1 1A1 2B 4A2 1A2 2C 4B 1B 3 4C 1B1 3A OC 1B2 3B 88 1C 3C 99 If not applicable, no code assigned in current AJCC manual, type 88. If not recorded, type 99. For further information, refer to the current *AJCC Cancer Staging Manual* for staging rules.

Item No.	Data Item/Field	Value to be Entered
		Do not leave this data item blank.
40. cont.	**TNM Path Descriptor:**	Identifies the AJCC pathologic stage (prefix/suffix) descriptor known ***following*** the completion surgical therapy. Valid 'Pathological Descriptor' codes are as follows: 0 None 1 E–Extranodal, lymphomas only 2 S–Spleen, lymphomas only 3 M–Multiple primary tumors in a single site 5 E&S–Extranodal and spleen, lymphomas only 9 Unknown; not stated in patient record Or double click on the appropriate code in the pull-down list. If there is no prefix or suffix descriptors that would be used for this case, type 0. If unknown, not stated, type 9. For further information, refer to the current *AJCC Cancer Staging Manual* for staging rules. ***Do not leave this data item blank.***
	TNM Edition Number:	Type the code that indicates the edition of the AJCC Cancer Staging Manual used to stage the case. Or click on the appropriate code in the pull-down list and press **Enter**. This applies to the manually coded AJCC fields and **not** the Derived AJCC T, N, M and AJCC Stage Group fields. If not staged (cases that have AJCC staging scheme and staging was not done), type 00. If not applicable (cases that do not have an AJCC staging scheme), type 88. If the Edition number is unknown, type 99.

Item No.	Data Item/Field	Value to be Entered ***Do not leave this data item blank.***
41.	**CS Tumor Size:**	Type the **largest dimension or diameter** of the **primary tumor** in millimeters. ***Example:*** 1.0 x 2.0 x 1.5 cm tumor is recorded as 020 Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. CS Tumor Size is a **required** data item regardless of facility type. *NOTE:* For LAB122 Display Type, the next required data item is Vital Status. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004.)***
42.	**CS Extension:**	Type the CS Extension code. Identifies contiguous growth (extension) of the primary tumor within the organ of origin or its direct extension into neighboring organs. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Date of Diagnosis fields to be entered first. Double click on the appropriate extension code or highlight and press **Enter**. You may need to use the scroll bar to display additional values. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
43.	**CS Tumor Size/Ext Eval:**	Type the code that identifies how the CS Tumor Size and CS Extension were determined based on the

Item No.	Data Item/Field	Value to be Entered
		diagnostic methods employed. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Date of Diagnosis fields to be entered first. Double click on the appropriate Eval code or highlight and press **Enter**. You may need to use the scroll bar to display additional values. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
44.	**CS Lymph Nodes:**	Type the code that identifies the Regional Lymph Nodes involved with cancer at the time of diagnosis either clinically or pathologically. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. You may need to use the scroll bar to display additional values. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
45.	**CS Lymph Nodes Eval:**	Type the code that identifies how the CS Lymph Nodes was determined based on the diagnostic methods employed. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. You may need to use the scroll bar to display additional values.

Item No.	Data Item/Field	Value to be Entered
		Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).
46.	**Regional Nodes Positive:**	Type the exact number of Regional Lymph Nodes identified pathologically that contain metastases. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
47.	**Regional Nodes Examined:**	Type the total number of Regional Lymph Nodes removed and examined pathologically. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Diagnosis of Date fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
48.	**CS Mets at DX:**	Type the code that identifies distant site(s) and/or distant lymph nodes with metastases at the time of diagnosis. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Diagnosis of Date fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. Use the scroll bar to display additional values. ***Do not leave this data item blank (unless the date***

Item No.	Data Item/Field	Value to be Entered
		of diagnosis is prior to January 1, 2004).
49.	**CS Mets at Dx-Bone:**	Type the code that identifies whether bone is an involved metastatic site. This field is a companion to CS Mets at DX field. Or double click on the appropriate code in the pull-down list. If CS Mets at DX is coded to 00, this field must be coded as 0. If CS Mets at DX is not coded to 00, this field may still be coded to 0 if bone is not a site of metastasis. Use code 8, when CS Mets at DX is coded as 98 (not applicable for this site). If unknown if bone metastases; not documented in patient record, type 9. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
50.	**CS Mets at DX-Brain:**	Type the code that identifies whether brain is an involved metastatic site. This field is a companion to CS Mets at DX field. Or double click on the appropriate code in the pull-down list. If CS Mets at DX is coded to 00, this field must be coded as 0. If CS Mets at DX is not coded to 00, this field may still be coded to 0 if brain is not a site of metastasis. Use code 8, when CS Mets at DX is coded as 98 (not applicable for this site). If unknown if brain metastases; not documented in patient record, type 9. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***

Item No.	Data Item/Field	Value to be Entered
51.	**CS Mets at DX-Liver:**	Type the code that identifies whether liver is an involved metastatic site. This field is a companion to CS Mets at DX field. Or double click on the appropriate code in the pull-down list. If CS Mets at DX is coded to 00, this field must be coded as 0. If CS Mets at DX is not coded to 00, this field may still be coded to 0 if liver is not a site of metastasis. Use code 8, when CS Mets at DX is coded as 98 (not applicable for this site). If unknown if liver metastases; not documented in patient record, type 9. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
52.	**CS Mets at DX-Lung:**	Type the code that identifies whether lung is an involved metastatic site. This field is a companion to CS Mets at DX field. Or double click on the appropriate code in the pull-down list. If CS Mets at DX is coded to 00, this field must be coded as 0. If CS Mets at DX is not coded to 00, this field may still be coded to 0 if lung is not a site of metastasis. Use code 8, when CS Mets at DX is coded as 98 (not applicable for this site). If unknown if lung metastases; not documented in patient record, type 9. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
53.	**CS Mets Eval:**	Type the code that identifies how the CS Metastases

Item No.	Data Item/Field	Value to be Entered
		at Diagnosis was determined. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires the Primary Site, Histology, Behavior, and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. Use the scroll bar to display additional values. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
54-78.	**Site-Specific Factors:**	**Collaborative Stage (CS) general coding instructions for Site-Specific Factors (SSFs) are as follows:**

CS General Coding Instructions – SSFs

Site-Specific Factor Field Requirements are modeled after the requirements set forth by the American College of Surgeons. Refer to file "CoC and SEER Combined Site Specific Factors List (140K.XLS)" located at http://seer.cancer.gov/tools/ssf/ for a complete listing of the SSF fields.

The information recorded in CS Site-Specific Factor fields differs for each anatomic site. See the most current version of the *Collaborative Stage Data Collection System* (http://www.cancerstaging.org/cstage/index.html), for further information on rules and site-specific codes and coding structures.

The Primary Site, Histology, Date of Diagnosis and Behavior codes must be entered first. Once entered, a check on primary site and histology is run to ascertain whether or not SSF25 is required for schema identification.

If SSF25 is required for schema identification, a Lookup window will appear. Double click on the appropriate code or highlight and press **Enter**.

If SSF25 is not applicable for the schema based upon the Primary Site and Histology codes entered, the automatic defaulting will delineate what SSFs are not defined for the identified schema, and the running of edits will delineate what SSFs are required.

If a SSF default value is 988, the field has been disabled (SSF not applicable for the schema based upon the Primary Site and Histology codes entered).

Item No.	Data Item/Field	Value to be Entered
	Site-Specific Factors:	**MCSP cancer reporting requirements for Site-Specific Factor (SSFs) are as follows:**

MCSP Cancer Reporting Requirements - SSFs

The Michigan Cancer Surveillance Program (MCSP) has created a color coded spreadsheet that indicates which SSF fields are required. This spreadsheet is named "MCSP SSF Requirements by Primary Site Jan 2013" and can be downloaded from the MCSP website at (http://www.michigan.gov/mdch/0,1607,7-132-2945_5221-16586--.00.html).

Collaborative Staging v02.04 requires values for ALL fields in abstracts submitted to the MCSP. Those SSF fields highlighted in orange will be REQUIRED (REQ) ***or*** REPORTABLE (REP) based upon facility type. For more information on facility types, refer to the "MCSP Reporting Requirements by Item and Facility Type Jan 2013" at (http://www.michigan.gov/mdch/0,4612,7-132-2945_5221-16586--,00.html).

NOTE: For LAB122 Display Type (Independent Laboratory), SSFs 1-25 are **not** Required.

Do not leave Site-Specific Factor fields blank (unless the date of diagnosis is prior to January 1, 2004).

Submission of data with REQUIRED or REPORTABLE Site Specific Factor fields left blank will be rejected by the MCSP.

Site-Specific Factors:	**MCSP level of reporting requirements for Site Specific Factor (SSFs) are as follows:**

MCSP Level of Reporting Requirements – SSFs

If a Site Specific Factor field is indicated as REQUIRED (REQ) or REPORTABLE (REP), the facility **must** collect and report the information with data collection efforts including review of the patient's hospital charts, outpatient record or other available records, but need not make inquiries of other facilities or physician's offices, as it is not the responsibility of the data collector to track down test results if they are not in the patient's medical record(s).

If there is no information available, refer to the "MCSP SSF Defaults Jan 2013" at (http://www.michigan.gov/mdch/0,4612,7-132-2945_5221-16586--,00.html) for the correct default code(s), ***OR*** to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate default code or highlight and press **Enter**.

Item No.	Data Item/Field	Value to be Entered
54.	**CS Site-Specific Factor 1:**	Type the CS Site-Specific Factor 1 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
55.	**CS Site-Specific Factor 2:**	Type the CS Site-Specific Factor 2 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
56.	**CS Site-Specific Factor 3:**	Type the CS Site-Specific Factor 3 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
57.	**CS Site-Specific Factor 4:**	Type the CS Site-Specific Factor 4 code needed to generate stage or prognostic/predictive factors.

Item No.	Data Item/Field	Value to be Entered
		Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
58.	**CS Site-Specific Factor 5:**	Type the CS Site-Specific Factor 5 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
59.	**CS Site-Specific Factor 6:**	Type the CS Site-Specific Factor 6 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
60.	**CS Site-Specific Factor 7:**	Type the CS Site-Specific Factor 7 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values,

Item No.	Data Item/Field	Value to be Entered
		click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
61.	**CS Site-Specific Factor 8:**	Type the CS Site-Specific Factor 8 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
62.	**CS Site-Specific Factor 9:**	Type the CS Site-Specific Factor 9 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
63.	**CS Site-Specific Factor 10:**	Type the CS Site-Specific Factor 10 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear.

Item No.	Data Item/Field	Value to be Entered
		Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
64.	**CS Site-Specific Factor 11:**	Type the CS Site-Specific Factor 11 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
65.	**CS Site-Specific Factor 12:**	Type the CS Site-Specific Factor 12 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
66.	**CS Site-Specific Factor 13:**	Type the CS Site-Specific Factor 13 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate

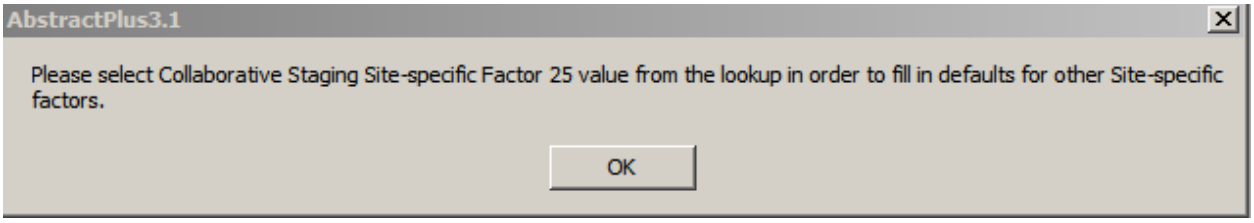
Item No.	Data Item/Field	Value to be Entered
		code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
67.	**CS Site-Specific Factor 14:**	Type the CS Site-Specific Factor 14 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
68.	**CS Site-Specific Factor 15:**	Type the CS Site-Specific Factor 15 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
69.	**CS Site-Specific Factor 16:**	Type the CS Site-Specific Factor 16 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date***

Item No.	Data Item/Field	Value to be Entered
		of diagnosis is prior to January 1, 2004).
70.	**CS Site-Specific Factor 17:**	Type the CS Site-Specific Factor 17 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
71.	**CS Site-Specific Factor 18:**	Type the CS Site-Specific Factor 18 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
72.	**CS Site-Specific Factor 19:**	Type the CS Site-Specific Factor 19 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
73.	**CS Site-Specific Factor 20:**	Type the CS Site-Specific Factor 20 code needed to

Item No.	Data Item/Field	Value to be Entered
		generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
74.	**CS Site-Specific Factor 21:**	Type the CS Site-Specific Factor 21 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
75.	**CS Site-Specific Factor 22:**	Type the CS Site-Specific Factor 22 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
76.	**CS Site-Specific Factor 23:**	Type the CS Site-Specific Factor 23 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values,

Item No.	Data Item/Field	Value to be Entered
		click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
77.	**CS Site-Specific Factor 24:**	Type the CS Site-Specific Factor 24 code needed to generate stage or prognostic/predictive factors. Or to display a searchable list of possible values, click the magnifying glass icon next to the field, or press the **F4** key and a Lookup window will appear. Use of the Lookup window requires a Primary Site, Histology, Behavior and Date of Diagnosis fields to be entered first. Double click on the appropriate code or highlight and press **Enter**. ***Do not leave this data item blank (unless the date of diagnosis is prior to January 1, 2004).***
78.	**CS Site-Specific Factor 25:**	Once the Primary Site and Histology codes are entered, a check on primary site and histology is run to ascertain whether or not SSF25 is required for schema identification. If SSF25 is required for the Primary Site and Histology entered, a pop-up box will appear. When you Click on the OK box, a Lookup window automatically opens.

Result: A **pop-up** box appears.



Double click on the appropriate code Site-Specific Factor 25 value or highlight and press **Enter**.

If SSF25 is not required for schema identification,

Item No.	Data Item/Field	Value to be Entered
		SSF25 will be defaulted to 988 and the field will be disabled. ***Do <u>not</u> leave this data item blank if SSF25 is required for schema identification.***
	Derived fields:	General instructions for the Derived Staging fields are as follows:
	 Note	Once all of the Collaborative Stage data elements have been coded, the values are passed through a computer program that generates the correct stage for the case in four systems: ***AJCC TNM 7th Edition; AJCC TNM 6th Edition; SEER Summary Stage 1977; and SEER Summary Stage 2000***. Pressing the **F5 key** in any derived field will calculate the AJCC Staging and SEER Summary Staging. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box. *NOTE 1:* Data for each Collaborative Stage (CS) field must be entered before pressing the F5 key to calculate the derived staging fields. *NOTE 2:* Calculation of the Derived fields **must** be completed if the <u>date of diagnosis</u> is January 1, 2004 forward. *NOTE 3:* AJCC 7th Edition stage is only calculated for cases diagnosed beginning January 1, 2010. ***Do <u>not</u> leave the Derived Fields blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived AJCC-6 T:	Pressing the **F5 key** in any derived field will calculate the AJCC-6T field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box.

Item No.	Data Item/Field	Value to be Entered
		Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).
	Derived AJCC-6 T Descript:	Pressing the **F5 key** in any derived field will calculate the AJCC-6T Descript field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived AJCC-6 N:	Pressing the **F5 key** in any derived field will calculate the AJCC-6N field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived AJCC-6 N Descript:	Pressing the **F5 key** in any derived field will calculate the AJCC-6N Descript field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging-fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived AJCC-6 M:	Pressing the **F5 key** in any derived field will calculate the AJCC-6M field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived AJCC-6 M Descript:	Pressing the **F5 key** in any derived field will calculate the AJCC-6M Descript field.

Item No.	Data Item/Field	Value to be Entered
		Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived AJCC-6 Stage Grp:	Pressing the **F5 key** in any derived field will calculate the AJCC-6 Stage Group field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived AJCC-7 T:	Pressing the **F5 key** in any derived field will calculate the AJCC-7T field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived AJCC-7 T Descript:	Pressing the **F5 key** in any derived field will calculate the AJCC-7T Descript field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived AJCC-7 N:	Pressing the **F5 key** in any derived field will calculate the AJCC-7N field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box.

Item No.	Data Item/Field	Value to be Entered
		Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).
	Derived AJCC-7 N Descript:	Pressing the **F5 key** in any derived field will calculate the AJCC-7N Descript field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived AJCC-7 M:	Pressing the **F5 key** in any derived field will calculate the AJCC-7M field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived AJCC-7 M Descript:	Pressing the **F5 key** in any derived field will calculate the AJCC-7M Descript field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived AJCC-7 Stage Grp:	Pressing the **F5 key** in any derived field will calculate the AJCC-7 Stage Grp field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived SS2000:	Pressing the **F5 key** in any derived field will calculate the SS2000 (SEER Summary Stage 2000)

Item No.	Data Item/Field	Value to be Entered
		field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived SS1977:	Pressing the **F5 key** in any derived field will calculate the SS1977 (SEER Summary Stage 1977) field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived AJCC-Flag:	Pressing the **F5 key** in any derived field will calculate the AJCC-Flag field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived SS2000 Flag:	Pressing the **F5 key** in any derived field will calculate the SS2000 Flag field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
	Derived SS1977 Flag:	Pressing the **F5 key** in any derived field will calculate the SS1977 Flag field. Or double click on the magnifying glass icon next to the field to compute **ALL** of the derived staging

Item No.	Data Item/Field	Value to be Entered
		fields. To exit, click on the close box. ***Do <u>not</u> leave this field blank (unless the date of diagnosis is prior to January 1, 2004).***
14.	**Comorbid/Complication 1:**	Depending on whether the hospital has implemented use of ICD-10-CM, this information may be identified either in ICD-9-CM or ICD-10-CM form. Do **<u>not</u>** mix ICD-9-CM and ICD-10-CM codes in the Comorbidity and Complications items. Secondary diagnoses are found on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available. Type the ICD-9-CM or ICD-10-CM code as it appears on the discharge abstract or as recorded by the billing department at your facility. Five digits must be entered in order for the code to pass edits. *Example:* 401.9 must be entered as 40190 Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters. If no secondary diagnoses were documented, type **00000**, press **Enter**, and leave the remaining Comorbidities and Complications data fields blank**.** If this information is unknown or not available, leave this data item blank.
14. cont.	**Comorbid/Complication 2:**	If only two comorbid conditions or complications were documented, type the ICD-9-CM or ICD-10-CM code for the second comorbid condition or complication as it appears on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available. Do **<u>not</u>** mix ICD-9-CM and ICD-10-CM codes in the Comorbidity and Complications items.

Item No.	Data Item/Field	Value to be Entered
		Five digits must be entered in order for the code to pass edits. *Example:* 401.9 must be entered as 40190 Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters. If no comorbid/complication documented, leave this data item blank.
14. cont.	**Comorbid/Complication 3:**	If only three comorbid conditions or complications were documented, type the ICD-9-CM or ICD-10-CM code for the third comorbid condition or complication as it appears on the discharge abstract. Information from the billing department at your facility may be consulted when a discharge abstract is not available. Do **not** mix ICD-9-CM and ICD-10-CM codes in the Comorbidity and Complications items. Five digits must be entered in order for the code to pass edits. *Example:* 401.9 must be entered as 40190 Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters. If no comorbid/complication documented, leave this data item blank.
14. cont.	**Comorbid/Complication 4:**	If only four comorbid conditions or complications were documented, type the ICD-9-CM or ICD-10-CM code for the four diagnoses listed, press **Enter** and leave the remaining Comorbidities and Complications data fields blank. Do **not** mix ICD-9-CM and ICD-10-CM codes in the Comorbidity and Complications items. Five digits must be entered in order for the code to pass edits. *Example:* 401.9 must be entered as 40190

Item No.	Data Item/Field	Value to be Entered
		Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters. If no comorbid/complication documented, leave this data item blank.
14. cont.	**Comorbid/Complication 5:**	If only five comorbid conditions or complications were documented, type the ICD-9-CM or ICD-10-CM code for the five diagnoses listed, press **Enter** and leave the remaining Comorbidities and Complications data fields blank. Do **not** mix ICD-9-CM and ICD-10-CM codes in the Comorbidity and Complications items. Five digits must be entered in order for the code to pass edits. *Example:* 401.9 must be entered as 40190 Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters. If no comorbid/complication documented, leave this data item blank.
14. cont.	**Comorbid/Complicaton 6:**	If only six comorbid conditions or complications were documented, type the ICD-9-CM or ICD-10-CM code for the six diagnoses listed, press **Enter** and leave the remaining Comorbidities and Complications data fields blank. Do **not** mix ICD-9-CM and ICD-10-CM codes in the Comorbidity and Complications items. Five digits must be entered in order for the code to pass edits. *Example:* 401.9 must be entered as 40190 Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters. If no comorbid/complication documented, leave this data item blank.
14. cont.	**Comorbid/Complication 7:**	If only seven comorbid conditions or complications were documented, type the ICD-9-CM or ICD-10-

Item No.	Data Item/Field	Value to be Entered
		CM code for the seven diagnoses listed, press **Enter** and leave the remaining Comorbidities and Complications data fields blank. Do **not** mix ICD-9-CM and ICD-10-CM codes in the Comorbidity and Complications items. Five digits must be entered in order for the code to pass edits. *Example:* 401.9 must be entered as 40190 Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters. If no comorbid/complication documented, leave this data item blank.
14. cont.	**Comorbid/Complication 8:**	If only eight comorbid conditions or complications were documented, type the ICD-9-CM or ICD-10-CM code for the eight diagnoses listed, press **Enter** and leave the remaining Comorbidities and Complications data fields blank. Do **not** mix ICD-9-CM and ICD-10-CM codes in the Comorbidity and Complications items. Five digits must be entered in order for the code to pass edits. *Example:* 401.9 must be entered as 40190 Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters. If no comorbid/complication documented, leave this data item blank.
14. cont.	**Comorbid/Complication 9:**	If only nine comorbid conditions or complications were documented, type the ICD-9-CM or ICD-10-CM code for the nine diagnoses listed, press **Enter** and leave the remaining Comorbidities and Complications data fields blank. Do **not** mix ICD-9-CM and ICD-10-CM codes in the Comorbidity and Complications items.

Item No.	Data Item/Field	Value to be Entered
		Five digits must be entered in order for the code to pass edits. *Example:* 401.9 must be entered as 40190 Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters. If no comorbid/complication documented, leave this data item blank.
14. cont.	**Comorbid/Complication 10:**	If ten comorbid conditions and complications were documented, type the ICD-9-CM or ICD-10-CM code for the ten diagnoses listed and press **Enter**. Do **not** mix ICD-9-CM and ICD-10-CM codes in the Comorbidity and Complications items. Five digits must be entered in order for the code to pass edits. *Example:* 401.9 must be entered as 40190 Some ICD-10-CM codes are more than 5 characters long. Only enter the first five characters. If no comorbid/complication documented, leave this data item blank.
14. cont.	**ICD Revision Comorbid:**	Type the ICD Revision Comorbid code. Or double click on the appropriate code in pull-down list. ***Do not leave this data item blank.***

ENTERING TREATMENT - 1ST COURSE INFORMATION

Item No.	Data Item/Field	Value to be Entered
79.	**RX Summ-Treatment Sta:**	Type the code that summarizes the status for all treatment modalities. Or double click on the appropriate code in the pull-down list. ***Do not leave this data item blank.***

Item No.	Data Item/Field	Value to be Entered
80a.	**Date of 1st Crs RX-CoC:**	Enter the year, month and day YYYYMMDD for the Date of First Course of Treatment. Consider all therapies that have been administered. This includes any surgery, radiation therapy, chemotherapy, hormone therapy or immunotherapy (biological response modifier therapy) that has been described as a recommended part of the treatment plan. Record the FIRST date that the patient received treatment. For cases of non-treatment, in which a physician decides not to treat a patient or a patient's family member or guardian declines all treatment, the date of first course of treatment is the date this decision was made. If unknown or not applicable, leave this data item blank.
80b.	**Date 1st Crs RX-CoC Flag:**	Type the code that explains why there is not an appropriate value in the corresponding Date of First Course of Treatment CoC field. Or double click on the appropriate code in the pull-down list. Leave this data item blank if full or partial date is recorded in Date of First Course of Treatment.
81.	**RX Summ-Systemic/Sur Seq:**	Type the code that explains the Sequencing of Systemic Therapy and Surgical Procedures given as part of the first course of treatment. Or double click on the appropriate code in pull-down list. ***Do not leave this data item blank.***
83a.	**RX Date-Surgery:**	If Surgery was performed, type the date of the most definitive surgical procedure in the YYYYMMDD format. Leave this data item blank if information regarding

Item No.	Data Item/Field	Value to be Entered
		surgery is unknown (e.g., recommended but unknown if given, or date not known; no information available) or not applicable (e.g., no surgery surgical procedure was performed).
83b.	**RX Date-Surgery Flag:**	Type the code that explains why there is no appropriate value in the corresponding RX Date Surgery field. Or double click on the appropriate code in the pull-down list. Leave this data item blank if a full or partial date is recorded in RX Date –Surgery.
84.	**RX Summ-Surg Prim Site:**	Type the Site-specific Surgery code for the most definitive surgical procedure. This includes treatment given at all facilities as part of the first course of treatment. Or to display a searchable list of possible values, click on the magnifying glass icon next to the field, or press the **F4** key and a Look-up window will appear. Use of the Lookup window requires the Primary Site and Histology codes to be entered first. Double click on the appropriate surgical code or highlight and press **Enter**. You may need to use the scroll bar to display additional values. ***Do not leave this data item blank.***
82.	**Reason No Surgery:**	Type the code for Reason No Surgery. Or double click on the appropriate code in pull-down list. ***Do not leave this data item* blank.**
85.	**RX Summ-Surg Oth Reg:**	Record the surgical removal of distant lymph nodes or other tissue (s)/organ(s) beyond the primary site. Or double click on the appropriate code in the pull-down list. ***Do not leave this data item blank.***

Item No.	Data Item/Field	Value to be Entered
86.	**RX Summ-Scope Reg Lymph Surg:**	Type the code that describes the removal, biopsy or aspiration of regional lymph node(s) at the time of surgery of the primary site or during a separate surgical event at all facilities. Or double click on the appropriate code in the pull-down list. ***Do not leave this data item blank.***
87.	**RX Summ-Surg/Rad Seq:**	Type the code for the Sequencing of Radiation and Surgery given as part of the first course of treatment. Or double click on the appropriate code in pull-down list. ***Do not leave this data item blank.***
88a.	**RX Date-Radiation:**	If Radiation Therapy was administered, type the date which radiation therapy began at any facility that is part of the first course of treatment in the YYYMMDD format. Leave this data item blank if information for Radiation Therapy is unknown or not applicable (e.g., no radiation therapy is planned or given, or radiation therapy planned, but not yet started and/or the start date is not available).
88b.	**RX Date-Radiation Flag:**	Type the code that explains why there is not an appropriate value in the corresponding RX Date Radiation therapy field. Or double click on the appropriate code in the pull-down list. Leave this data item blank if a full or partial date is recorded in RX Date-Radiation.
	RX Summ-Radiation:	Record the code for the type of radiation therapy performed as part of the first course of therapy. Or double click on the appropriate code in pull-down list. You may need to use the scroll bar to display additional values.

Item No.	Data Item/Field	Value to be Entered
		Do not leave this data item blank.
90.	**Rad-Regional RX Modality:**	Record the dominant modality of radiation therapy used to deliver the most clinically significant dose to the primary volume of interest during the first course of treatment. Or double click on the appropriate code in pull-down list. You may need to use the scroll bar to display additional values. ***Do not leave this data item blank.***
89.	**Reason No Radiation**	Record the Reason that No Regional Radiation therapy was administered to the patient. Or double click on the appropriate code in pull-down list. You may need to use the scroll bar to display additional values. ***Do not leave this data item blank.***
91a.	**RX Date-Chemo:**	If Chemotherapy was administered, type the date treatment first began at any facility that is part of the first course of treatment in the YYYYMMDD format. Leave this data item blank if information regarding Chemotherapy is unknown or not applicable (e.g., no chemotherapy is planned or given; or chemotherapy planned, but not yet started and/or the start date is not available).
91b.	**RX Date-Chemo Flag:**	Type the code that explains why there is not an appropriate value in the corresponding RX Date Chemotherapy field. Or double click on the appropriate code in the pull-down list. Leave this data item blank if a full or partial date is recorded in RX Date-Chemo.
92.	**RX Summ-Chemo:**	Type the code for Chemotherapy given as part of the

Item No.	Data Item/Field	Value to be Entered
		first course of treatment or the reason chemotherapy was not given. Includes treatment given at all facilities as part of the first course of treatment. Or double click on the appropriate code in pull-down list. You may need to use the scroll bar to display additional values. ***Do not leave this data item blank.***
	RX Date-Systemic:	Type the date of initiation of Systemic Therapy that is part of the first course of treatment in the YYYYMMDD format. *NOTE:* Systemic therapy includes *Chemotherapy; Hormone Therapy; Biological Response Modifiers; Bone Marrow Transplants; Stem Cell Harvests; and Surgical and/or Radiation Endocrine Therapy.* Leave this data item blank if information for Date Systemic Therapy Started is unknown or not applicable (e.g., no systemic therapy planned or given, or planned but not yet stared and/or the start date is not available).
	RX Date-Systemic Flag:	Type the code that explains why there is not an appropriate value in the corresponding RX Date Systemic field. Or double click on the appropriate code in the pull-down list. Leave this data item blank if a full or partial date is recorded in RX Date-Systemic.
94a.	**RX Date-Hormone:**	If Hormone Therapy was administered, type the date treatment first began at any facility that is part of the first course of treatment in the YYYYMMDD format. Leave this data item blank if information regarding Date Hormone Therapy is unknown or not applicable (e.g., no hormone therapy is planned or given; or hormone therapy planned, but not yet started and/or the start date is not available).

Item No.	Data Item/Field	Value to be Entered
94b.	**RX Date-Hormone Flag:**	Type the code that explains why there is not an appropriate value in the corresponding RX Date Hormone therapy field. Or double click on the appropriate code in the pull-down list. Leave this data item blank if a full or partial date is recorded in RX Date-Hormone.
95.	**RX Summ-Hormone:**	Type the code for Hormone therapy administered as part of first course of therapy. Or double click on the appropriate code in the pull-down list. ***Do not leave this data item blank.***
93.	**RX Summ-Transplnt/End:**	Type the code for Transplant/Endocrine procedures administered as part of the first course of treatment at this and all other facilities. Or double click on the appropriate code in the pull-down list. You may need to use the scroll bar to display additional values. ***Do not leave this data item blank.***
96a.	**RX Date-BRM:**	Type the date of initiation for Immunotherapy (a.k.a. biological response modifier) at any facility in the YYYYMMDD format. Leave this data item blank if information for Date Biological Response Modifier (Immunotherapy) is unknown or not applicable (e.g., no BRM is planned or given; or BRM planned, but not yet started and/or the start date is not available).
96b.	**RX Date-BRM Flag:**	Type the code that explains why there is not an appropriate value in the corresponding Date BRM field. Or double click on the appropriate code in the pull-down list.

Item No.	Data Item/Field	Value to be Entered
		Leave this data item blank if a full or partial date is recorded in RX Date-BRM.
97.	**RX Summ-BRM:**	If Biological Response Modifier (a.k.a. Immunotherapy) agents were administered, type the code for BRM, which began at any facility that is part of the first course of treatment. Or double click on the appropriate code in the pull-down list. You may need to use the scroll bar to display additional values. ***Do not leave this data item blank.***
98a.	**RX Date-Other:**	Type the date that Other Treatment began at any facility in the YYYYMMDD format. (Other Treatment is that which cannot be defined as surgery, radiation, or systemic therapy.) Leave this data item blank if information for Date Other Treatment is unknown or not applicable (e.g., no Other Therapy is planned or given; or Other Therapy planned, but not yet started and/or the start date is not available.)
98b.	**RX Date-Other Flag:**	Type the code that explains why there is not an appropriate value in the corresponding Date Other Therapy field. Or double click on the appropriate code in the pull-down list. Leave this data item blank if a full or partial date is recorded in RX Date-Other.
99.	**RX Summ-Other:**	Type the code for Other Treatment administered as part of the first course of treatment at this and all other facilities. Or double click on the appropriate code in the pull-down list. You may need to use the scroll bar to display additional values. ***Do not leave this data item blank.***

ENTERING FOLLOW-UP RECURRENCE/DEATH INFORMATION

Item No.	Data Item/Field	Value to be Entered
107.	**Vital Status:**	Type the Vital Status code as of the date entered in the Date of Last Contact field. If the patient is dead, type 0. If the patient is alive, type 1. Or double click on the appropriate code in the pull-down list. ***Do not leave this data item blank.***
100a.	**Date of Last Contact:**	Type the date of Last Contact of the patient, or the date of death in the YYYYMMDD format. If unknown or not applicable, leave this data item blank.
100b.	**Date of Last Contact Flag:**	Type the code that explains why there is not an appropriate value in the corresponding Date of Last Contact field. Or double click on the appropriate code in the pull-down list. Leave this data item blank if a full or partial date is recorded in Date of Last Contact.
109.	**Cause of Death:**	Type the official Cause of Death code from the death certificate. If patient alive at last contact, type 0000. If death certificate not available, type 7777. If death certificate available but underlying cause of death not coded, type 7797. Or **click** in the **Cause of Death** box to open the information window and type the appropriate 4-digit code. ***Do not leave this data item blank.***

Item No.	Data Item/Field	Value to be Entered
	ICD Revision Number:	Type the ICD revision code used for Cause of Death. Or double click on the appropriate code in the pull-down list. If patient is alive at Date of Last Contact, leave the preset default code 0 and press **Enter**. ***Do not leave this data item blank.***
110.	**Place of Death:**	Type the Death Place code. If patient is alive, type 997. Or to display a searchable list of possible values, click on the magnifying icon next to the field, or press the **F4** key and a Lookup window will appear. Type the Place of Death in the search box and double click on the appropriate code. Or use the arrow keys within the Lookup window and double click on the appropriate code or highlight and press **Enter**. ***Do not leave this date item blank.***

ENTERING OVER-RIDES/CON/SYSTEM ADMIN. INFORMATION

Some computer edits will identify errors within the abstract. Others indicate possible errors that require manual review for resolution. To eliminate the need to review the same cases repeatedly, over-ride flags have been developed to indicate that data in a record (or records) have been reviewed and, while unusual, are correct.

If the computer edits identify an error, supporting text documentation **must** be provided in the Remarks Text Field to support the use of an over-ride code.

Item No.	Data Item/Field	Value to be Entered
	Over-ride:	General instructions for all Over-ride fields are as follows:

Item No.	Data Item/Field	Value to be Entered
		Leave blank if the program does not generate an error message. Leave blank and correct any errors for the case if an item is discovered to be incorrect. If the case has been reviewed and it has been verified that the case has been coded correctly, double click on the appropriate code in the pull-down list. For more information on the edit error, right click in the Over-ride field, highlight Field Context Help and left click or press **Enter**.
	MI Update Flag:	This field is used to indicate whether this is a new cancer report form or an update of a previously submitted cancer report. Double click on the appropriate code in the pull-down list. If the report is an Update, go to Chapter12, page 167. ***Do not leave this data item blank.***

ENTERING INFORMATION INTO TEXT FIELDS

The NAACCR Volume II Data Dictionary defines Text Documentation as an essential component of a complete electronic abstract. Text information is heavily utilized for quality control and special studies, and is needed to justify coded values and to document supplemental information not transmitted within coded values. High-quality text documentation facilitates consolidation of information from multiple reporting sources at the central registry.

The text field **must** contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process should be entered manually from the medical record and should not be generated electronically from coded values. If cancer abstraction software generates text automatically from codes, the text cannot be utilized to check coded values.

When the supporting text information is printed for review, one should be able to re-abstract the case without obtaining additional medical records and have the same codes as the original abstract.

In Abstract Plus, the various text fields are presented within the data entry grid on the right side of the Abstracting Window. The order and names of the names of the text fields you see is specified by the MCSP upon set up of the software.

For further information, refer to the NAACCR Volume II, Data Standards and Data Dictionary at http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx

Item No. Text Field

Value to be Entered

General information/instructions for Text Fields are as follows.

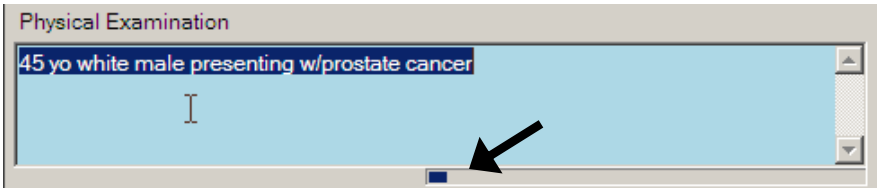
The text field must contain a description that has been entered by the abstractor independently from the code(s).

Information documenting the disease process and treatments provided should be entered manually from the medical record.

It is best practice to abstract all available text information prior to entering codes for any of the coded cancer identification of treatment data items.

You can scroll up and down in the text entry grid separate from the data entry grid on the left, facilitating the concurrent viewing of text and codes.

Note that when entering text, a helpful progress bar is displayed below each text field that indicates how much space is left so that you can properly prioritize the information you are entering.



Line returns are not allowed in Abstract Plus text fields. Pressing Enter will move the cursor to the next text field in the text entry grid.

Text automatically generated from coded data is NOT acceptable.

For text documentation that is continued from one text field to another, use asterisks or other symbols

Item No.	Text Field	Value to be Entered
		to indicate the connection with previous. If there is no information to record in the text field, do **not** leave the field blank. Type 'N/A' or 'No Info' in the appropriate text field to indicate that there is no information, otherwise it will be assumed that the information is actually missing. Do **not** include irrelevant information. ***Do not leave text fields blank. (If not applicable, type N/A.)***
101.	**Physical Examination (PE):**	Text area for the history and physical examination related to the current tumor and the clinical description of the tumor. ***Required for Text:*** • Date of physical exam • Age, sex, race/ethnicity • History that relates to cancer diagnosis • Histology (if diagnosis prior to this admission) • Tumor size • Palpable lymph nodes • Record positive and negative clinical findings; record positive results first • Impression (when stated and pertains to cancer diagnosis) • Treatment plan ***Example:*** • 2012/02/15: 49 yo white, non-Hispanic male presenting w/enlarged prostate. Retired farmer. ***Do not leave this data item blank. (If not applicable, type N/A)***
102.	**X-Rays/Scans:**	Text area for all X-rays, scan, and/or other imaging examinations that provide information about staging. ***Required for Text:*** • Date(s) of X-ray/Scan(s) • Age, sex, race/ethnicity (when given) • Primary site

Item No.	Text Field	Value to be Entered
		• Histology (if given) • Tumor location • Tumor size • Lymph nodes • Record positive and negative clinical findings. Record positive results first • Distant disease or metastasis ***Key Information:*** Size and location of primary tumor; relationship of mass to other tissues, such as impingement or extension to another tissue (ribs, chest wall, pleura); elevation of diaphragm on one side (phrenic nerve paralysis); hilar or mediastinal involvement; enlargement or decrease in size of lung(s); opacity, such as atelectasis, pleural effusion or pneumonitis; masses in mediastinum and/or hilum of lung; involvement of distant sites. ***Examples:*** • 2012/02/18: Bone Scan: None, no metastases • 2012/07/03: MRI: Involvement of skull base • 09/12/2012: Mammogram: 1.5cm lesion right upper outer quadrant (UOQ) suspicious for neoplasm ***Do not leave this data item blank. (If not applicable, type N/A)***
103.	**Scopes (Endoscopic Exam):**	Text area for endoscopic examinations that provide information for staging and treatment. ***Required for Text:*** • Date(s) of endoscopic exam(s) • Primary site • Histology (if given) • Tumor location • Tumor size • Lymph nodes • Record positive and negative clinical findings. ***Example:*** • 2012/07/02: Colonoscopy: A 2.5 cm mass located at 25cm. 1.0cm polyp at 15cm. Biopsy

Item No.	Text Field	Value to be Entered
		recommended. ***Do not leave this data item blank. (If not applicable, type N/A)***
101.	**Lab Tests:**	Text area for information from laboratory examinations other than cytology or histopathology. Data should verify/validate the coding of the following fields: Date of Diagnosis, Primary Site, Laterality, Histology ICD-O-3, Grade, Collaborative Stage variables, Diagnostic confirmation. ***Note:*** **Not Cytology or Histopathology.** ***Required for Text:*** • Type of lab test/tissue specimen(s) • Record both positive and negative findings, record positive test results first. • Information can include tumor markers, serum and urine electrophoresis, special studies, etc. • Date(s) of lab test(s) • Tumor markers included, but are not limited to o Breast Cancer: Estrogen Receptor Assay (ERA), Progesterone Receptor Assay (PRA), HER 2/neu. o Prostate Cancer: Prostatic Specific Antigen (PSA) o Testicular Cancer: Human Chorionic Gonadotropin (hCG), Alpha Fetoprotein (AFP), Lactate Dehydrogenase (LDH ***Examples:*** • 02/15/2012: PSA elevated 4.6 ng/ml • 2012/04/20: ER/PR positive or (+), HER2 negative or (-) ***Do not leave this data item blank. (If not applicable, type N/A)***
84.	**OP/Surgical Procedures:**	Text area for manual documentation of all surgical procedures that provide information for staging. Data should verify/validate the coding of the following fields: Date of 1st positive Bx; Date of

Item No.	Text Field	Value to be Entered
		Diagnosis; Rx Summary diagnostic-staging procedures; Rx Summary -Surgery at primary site. ***Required for Text:*** • Dates and descriptions of biopsies and all other surgical procedures from which staging information was derived. • Number of lymph nodes removed • Size of tumor removed • Documentation of residual tumor • Evidence of invasion of surrounding areas ***Examples:*** • 02/20/2012: TURP: Incidental finding of adenocarcinoma in situ, 0.1mm. No enlarged lymph nodes. • 2012/01/25: Obstructing lung tumor very close to the main stem bronchus directly extending into the trachea. Enlarged mediastinal lymph nodes. ***Do not leave this data item blank. (If not applicable, type N/A)***
103.	**Pathology:**	Review the pathology report and type in the text from cytology and histopathology reports. ***Required for Text:*** • Date(s) of procedure(s) • Type of tissue specimen(s) • Tumor type and grade (include all modifying adjectives, e.g., predominantly, with features of, with foci of, elements of, etc.) • Gross tumor size; Extent of tumor spread; Involvement of resection margins • Number of lymph nodes involved and examined • Record any additional comments from the pathologist, including differential diagnoses considered and any ruled out or favored • Note if the pathology report is a slide review or a second opinion from an outside source (e.g., AFIP, Mayo, etc.) • Record any additional comments from the pathologist, include differential diagnoses

Item No.	Text Field	Value to be Entered
		considered, notes, comments, addenda, and any ruled out or favored ***Examples:*** • 11/12/2012 colon polyp, 1.2x1.0x.0.8 cm. Adenocarcinoma contained within polyp showing invasion of submucosa. Stalk: no evidence of adenocarcinoma or dysplasia. • 2012/07/04 mastectomy of breast for R upper outer quadrant mass; 1.0 x 1.3 x .9 cm. Ductal carcinoma, infiltrating, Grade III. Margins clear; 01/12/12: lymph nodes negative for cancer; no metastasis noted; Positive histology; ERA negative. ***Do not leave this data item blank. (If not applicable, type N/A)***
31.	**Primary Site Title:**	Type text information describing the primary site and laterality of the tumor being reported. Be as specific as possible, as many organs can be sub-divided into specific segments. ***Example:*** • The pathology report indicates adenocarcinoma of the left upper lobe, lung. *Record the primary site as "Lung, left upper lobe," or "Lung, LUL."* Do **not** report the metastatic site as the primary site. If the primary site cannot be determined, type "Unknown Primary Site." ***Do not leave this data item blank. (If not applicable, type N/A)***
33a.	**Histology Title:**	Review the pathology report and type in the histologic type (adenocarcinoma, squamous cell cancer, etc.), the *behavior* (malignant, in situ, benign), and the tumor grade (differentiation) of the tumor being reported. ***Required for text:*** • Histologic type and behavior • Information on differentiation from scoring

Item No.	Text Field	Value to be Entered
		system such as Gleason score, Bloom-Richardson for tumor grade; laterality (if paired site) ***Examples:*** • Invasive adenocarcinoma, NOS • DCIS, comedo and cribriform type • Infiltrating lobular and ductal carcinoma • Superficial spreading malignant melanoma • Infiltrating squamous cell carcinoma, Keratinizing • Adenocarcinoma, compatible with non-small cell carcinoma • Nodular sclerosis classical Hodgkin lymphoma, grade not stated • Follicular lymphoma, grade 2, B-cell • Mixed phenotype acute leukemia with t(v;11q23); MLL rearranged ***Do not leave this data item blank. (If not applicable, type N/A)***
103.	**Staging:**	Additional text area for staging information not already entered in the Test—Dx Proc areas. ***Required for Text:*** • Date(s) of procedure(s), including clinical procedures, that provided information for assigning stage • Organs involved by direct extension • Size of tumor • Status of margins • Number and sites of positive lymph nodes • Site(s) of distant metastasis • Physician's specialty and comments • Physician's stage for AJCC ***Examples:*** • 2012/02/04: Low anterior resection: Involvement of subcutaneous tissue, regional LNs negative or (-), no bone mets, remainder of exam within normal limits or remainder of exam WNL

Item No.	Text Field	Value to be Entered
		• 2012/07/05: PE: Physician states nodes are clinically negative. • 2012/03/15: TAH BSO: Extension to adjacent peritoneum, implants on pelvic wall • 2012/05/01: TAH without BSO: FIGO Stage IIC • 2012/06/01: Segmental resection of colon: Regional by direct extension & regional nodes • 2012/12/12: TNM Staging Form: T1, N0, M0 ***Do not leave this data item blank. (If not applicable, type N/A)***
84.	**Surgery:**	Type the text information briefly describing the surgical procedures performed for treatment. ***Required for text:*** • Date of each procedure • Type(s) of surgical procedure(s), including excisional biopsies and surgery to other and distant sites • Lymph nodes removed • Regional tissues removed • Metastatic sites • Facility where each procedure was performed • Record positive and negative findings; record positive findings first ***Examples:*** • 2012/01/25: Pneumonectomy, NOS, with mediastinal lymph node dissection: Obstructing lung tumor very close to the main stem bronchus directly extending into the trachea. • 04/02/2012: Skin, Right arm: Mos with 1-cm margin • 08/02/2012: Modified radical mastectomy without removal of uninvolved contralateral breast ***Do not leave this data item blank. (If not applicable, type N/A)***
105.	**Radiation (Beam):**	Type the text information regarding treatment of the tumor being reported with beam radiation.

Item No.	Text Field	Value to be Entered
		Required for text: • Start date when radiation treatment began • Where treatment was given (e.g., at this facility; at another facility) • Type(s) of beam radiation (e.g., Orthovoltage, Cobalt 60, MV X-rays, Electrons, Mixed modalities) • Other treatment information (e.g., patient discontinued after five treatments; unknown if radiation was given) ***Examples:*** • 2012/01/05: 6MV photons at ____ • 2012/06/01: Cesium-137, facility unknown • 2012/09/01: 4,500 cGY to the head and neck region with 8 MV photons • 07/22/2012: Pelvic irradiation to 5,000 cGY, boost to 7,000 cGY ***Do not leave this data item blank. (If not applicable, type N/A)***
105.	**Radiation (Other):**	Type the text for information regarding treatment of the tumor being reported with radiation other than beam radiation. This includes brachytherapy and systemic radiation therapy. ***Required for text:*** • Date treatment was started • Where treatment was given (e.g., at this facility; at another facility) • Type(s) of non-beam radiation (e.g., High Dose rate brachytherapy, seed implant, Radioisotopes [I-131]) • Other treatment information (e.g., unknown if radiation was given) ***Example:*** • 2012/06/14: Radioisotopes [I-131] at (include name/location of facility if known) ***Do not leave this data item blank. (If not applicable, type N/A)***

Item No.	Text Field	Value to be Entered
104.	**Chemotherapy:**	Type the text for information regarding chemotherapy treatment of the reported tumor. ***Required for text:*** • Date when chemotherapy began • Where treatment was given, (e.g., at this facility; at another facility) • Type of chemotherapy (e.g., name of agent or agents) or protocol • Other treatment information (e.g., treatment cycle incomplete, unknown if chemotherapy was given) ***Examples:*** • 2012/07/03: Patient received 6 cycles of CHOP at (include name of facility if known) • 2012/09/15: Per Oncology Report Summary, patient received Adriamycin starting in 09/12 (day not recorded). ***Do not leave this data item blank. (If not applicable, type N/A)***
104.	**Hormone Therapy:**	Type the text for information about hormonal cancer-directed treatment. ***Required for text:*** • Date treatment was started • Where treatment was given (e.g., at this facility; at another facility) • Type of hormone or antihormone (e.g., Tamoxifen • Type of endocrine surgery or radiation (e.g., Orchiectomy • Other treatment information (e.g., treatment cycle incomplete, unknown if hormones were given) ***Examples:*** • 2012/01/15: Per Oncology Treatment Summary Report: Patient started Tamoxifen therapy January 2012, day unknown • Discharge summary: Patient treated with Lupron

Item No.	Text Field	Value to be Entered
		hormonal therapy, starting on 07/12/2012 ***Do not leave this data item blank. (If not applicable, type N/A)***
104.	**BRM:**	Type the text area for information regarding the treatment of the tumor being reported with biological response modifiers or immunotherapy. ***Required for text:*** • Date treatment began • Where treatment was given (e.g., at this facility; at another facility) • Type of BRM agent (e.g., Interferon, BCG) • BRM procedures (e.g., bone marrow transplant, stem cell transplant) • Other treatment information (e.g., treatment cycle incomplete; unknown if BRM was given) ***Example:*** • 2012/05/03: BCG (include name of facility/location if known) ***Do not leave this data item blank. (If not applicable, type N/A)***
104.	**Other:**	Type the text for information regarding the treatment of the tumor being reported with treatment that cannot be defined as surgery, radiation, or systemic therapy. *NOTE:* This includes experimental treatments (when the mechanism of action for a drug is unknown) and blinded clinical trials. If the mechanism of action for the experimental drug is known, code to the appropriate treatment field. ***Required for text:*** • Date treatment was started • Where treatment was given (e.g., at this facility; at another facility) • Type of other treatment (e.g., blinded clinical trial, hyperthermia) • Other treatment information (e.g., treatment

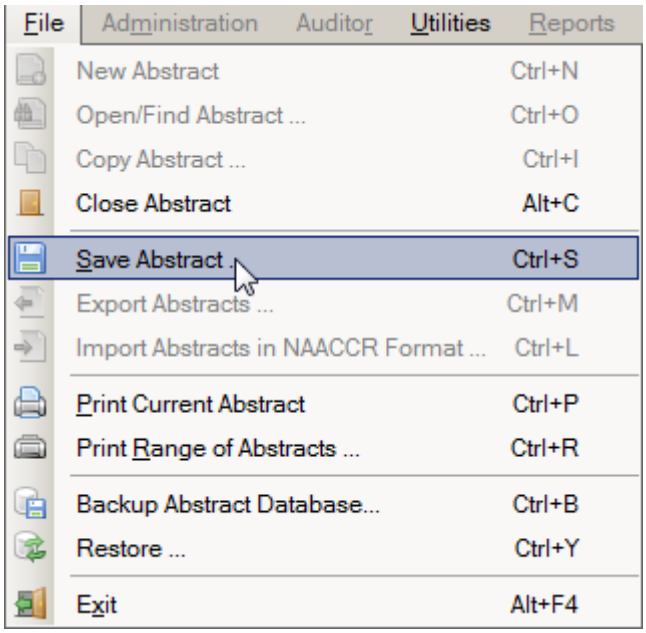
Item No.	Text Field	Value to be Entered
		cycle incomplete, unknown if other treatment was given)
105.	**Remarks:**	Type the text for information that is given only in coded form elsewhere or for which the abstract provides no other place. *NOTE:* Type the text for information for Family Medical History, Alcohol History and Tobacco History in **Remarks** text field. ***Required for text:*** • Overflow data can be placed here • Problematic coding issues (e.g., information clarifying anything unusual such as reason for reporting a case seemingly not reportable for that facility or reason for coding numerous fields as "unknown.") • Smoking history • Family and personal history of cancer (include type and age of onset for each individual if documented) • Comorbidities • Information on sequence numbers if a person was diagnosed with another primary out-of-state or before the registry's reference date • Place of birth • Justification of over-ride flags ***Examples:*** • 2012/07/09: PE: Family medical history or FMH: 1 sister w/hx of breast cancer. Social Medical History or SMH: No current or previous history of alcohol or tobacco use. PMH: History of stage T2, N0 M0 breast cancer treated with lumpectomy followed by radiation therapy. • 04/16/2012: Consultation report: FMH/PMH negative, SMH: cigarettes, 1ppd x 40 years, quit 5 years ago ***Do not leave this data item blank. (If not applicable, type N/A)***

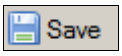
Item No.	Text Field	Value to be Entered
	Place of Diagnosis:	Type the text for the facility, physician office, city, state, or county where the diagnosis was made. ***Required for text:*** • The complete name of the hospital or the physician office where diagnosis occurred. The initials of a hospital are not adequate. • For out-of-state residents and facilities, include the city and the state where the medical facility is located If unknown, type Unknown. If not applicable, type N/A. ***Do not leave this data item blank.***
	Local Text:	***Do <u>not</u> use the Local Text field. (This is a State central cancer registry defined user field.)*** ***NOTE: Leave this data item blank.***

Saving Abstracts

Once you have entered information into an abstract, it is a good idea to save your work often. To save your work, complete these steps.

1. Saving an abstract can be done in three ways.
    a. Click on the **File** menu, and select **Save Abstract**.



b. Click the Save icon on the tool bar. 

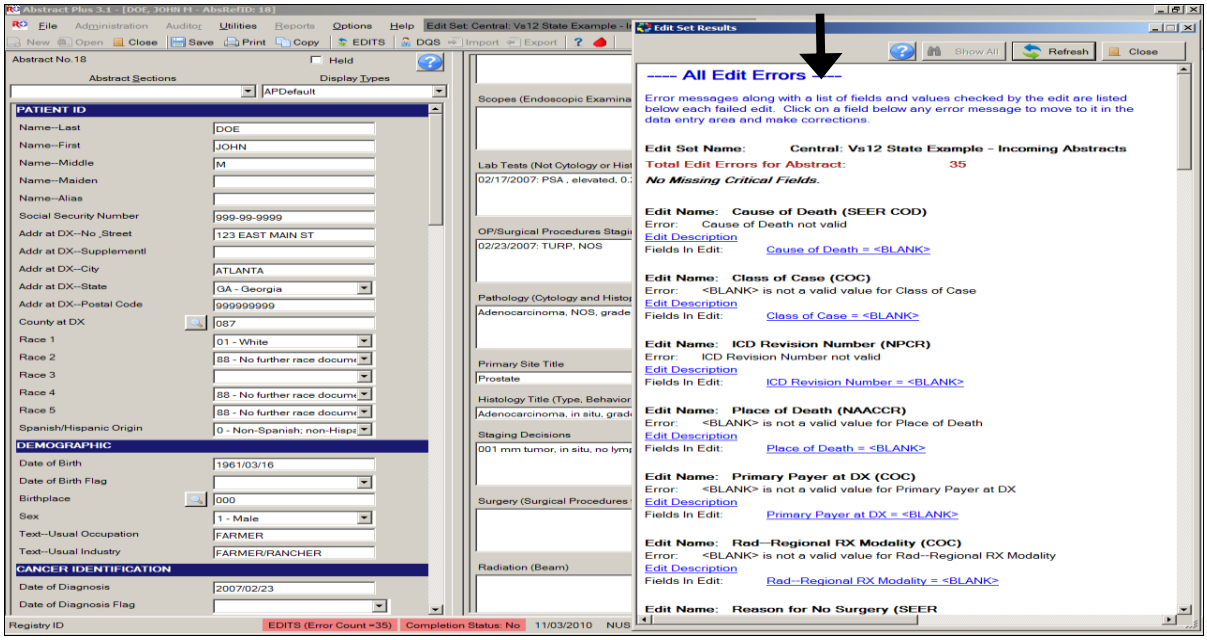
c. Use the keystroke **Ctrl+S**.

Results:

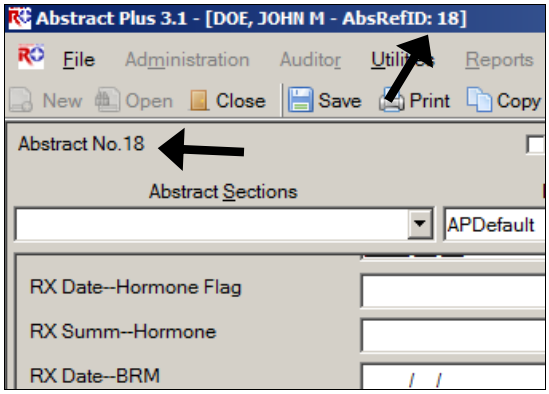
1) The **information entered thus far for the abstract is saved** to the database.

2) Edits will run (depending on the way your Abstract Plus Administrator set up your Abstract Plus application).

3) The **Edit Set Results window** opens and displays information about any edit errors the abstract may contain.



4) Once saved, each abstract is assigned an unique **Abstract Reference ID** (or AbsRefID), displayed in the upper left-hand corner of the data entry area of abstracting window, as well as, in the title bar of the application along with the patient name.



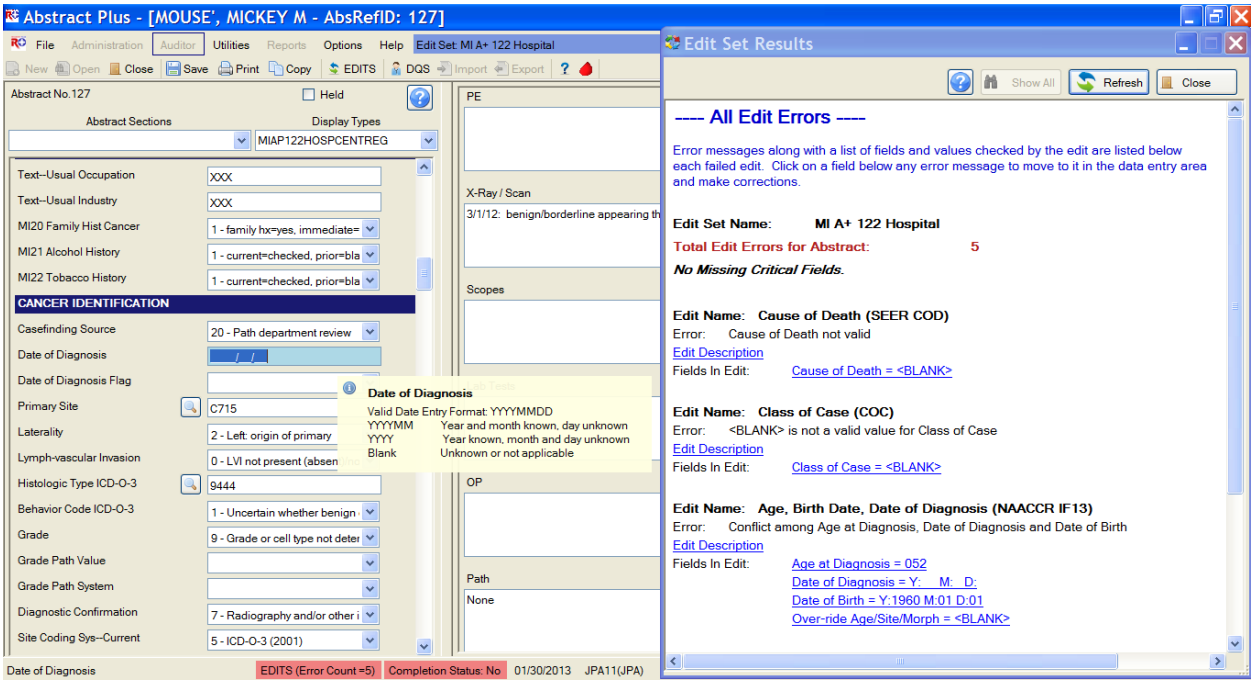
5) The **EDITS Error Count** and Abstract **Completion Status** indicators reflect the current edit error count and completion status (Yes or No) of the abstract. If there are any errors within the abstract, both of these indicators will display in red. In the example shown, the abstract contains 35 edit errors and as a result, is deemed incomplete.

Data Quality Edits and Error Resolution Features

Each time an abstract is opened or saved; Abstract Plus automatically edits the entered information for accuracy and completeness using the edit set and required fields chosen by your Abstract Plus Administrator.

You must resolve all edit errors and fill in all critical (required) fields in order to **complete** the abstract.

Abstract Plus version 3.2.1.0 has edit error display features that greatly facilitate the error resolution process. Editing features include display of the **name of the edit set** being run at the top of the abstracting window and an all-new **Edit Set Results** window. Please see page 110 of this training manual, for more information regarding Abstract Plus editing features.



Correcting Edit Errors

For any abstract, you can run edits and view edit errors by **saving** the abstract, clicking the **EDITS** button on the toolbar, or **pressing F8**.

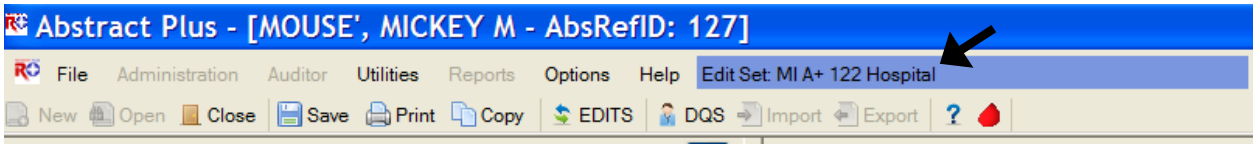
Each time an abstract is opened or saved Abstract Plus automatically edits the entered information for accuracy and completeness using the edit set and required fields chosen by your Abstract Plus Administrator.

You must resolve all edit errors and fill in all critical (required) fields in order to **complete** the abstract.

Abstract Plus version 3.2.1.0 has edit error display features that greatly facilitate the error resolution process. Editing features include.

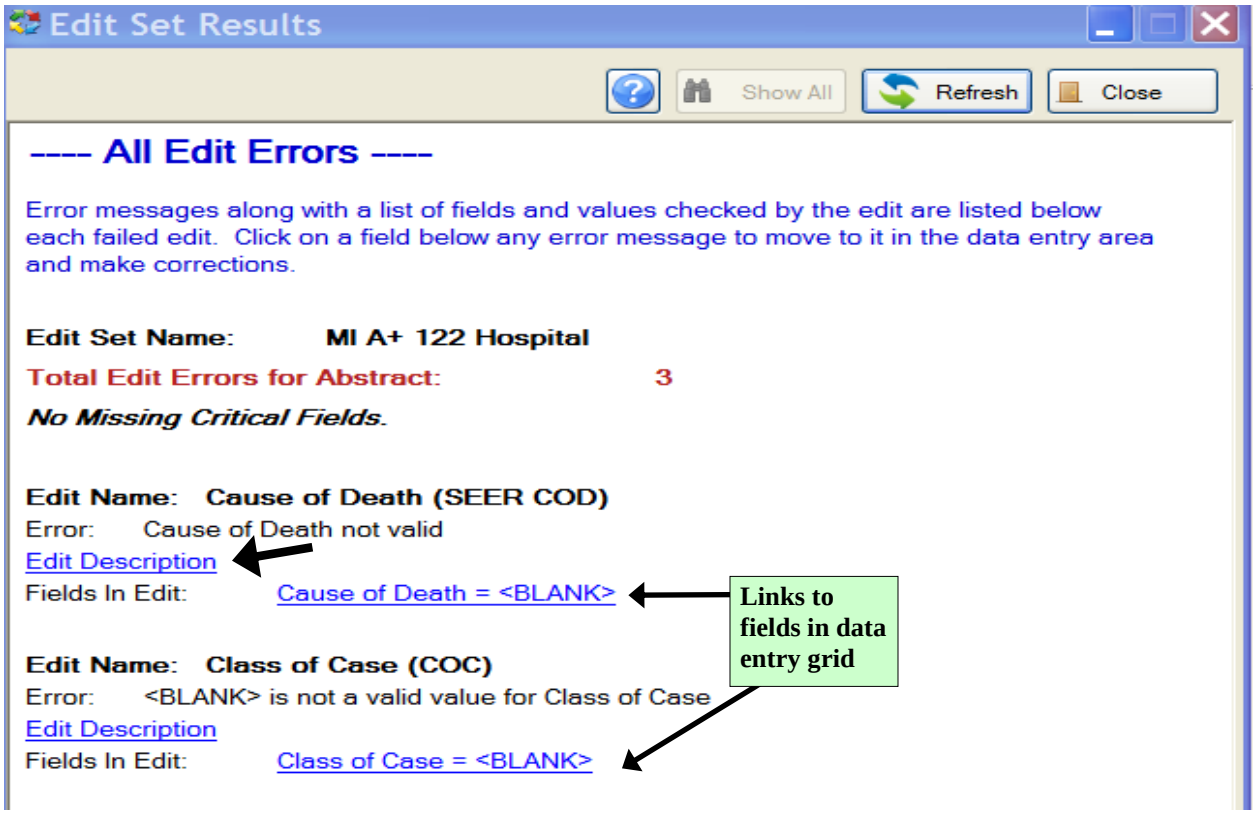
a. The **edit set** being run on the abstract is clearly **displayed** at the top of the abstracting window. In the example shown, the edit set being applied is named **MI A+ 122 Hospital**

Hospital Example: Incoming Abstracts:

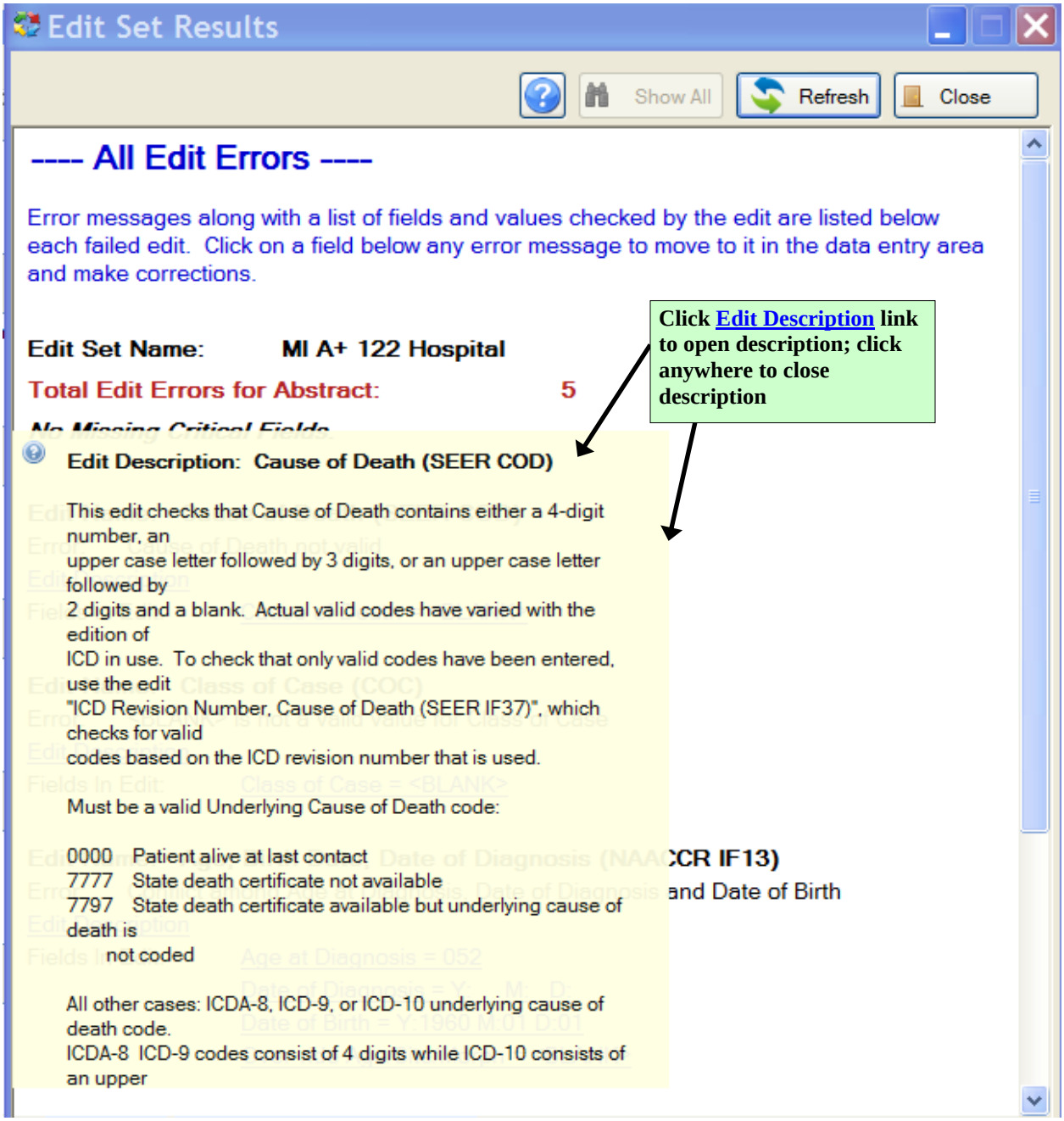


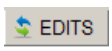
b. When edits are run, the **Edit Set Results** window automatically opens and displays the full information for any edit errors that exist, or lets you know that there are no errors. The Edit Set Results window lists the total number of edit errors for the abstract, missing critical

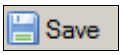
(required) fields, and the edit errors. For each edit error, the failed edit name, error message, and fields involved in the edit are listed. Using the information listed in the Edit Set Results window to help you resolve the edit errors, you can click on a link to a field to move to it in the data entry grid and make corrections.



When greater detail regarding the edit is required to resolve the edit error, click on the **Edit Description link**, which expands to display the edit description; once opened, you can **click** anywhere in the **Edit Set Results** window to close the edit description.

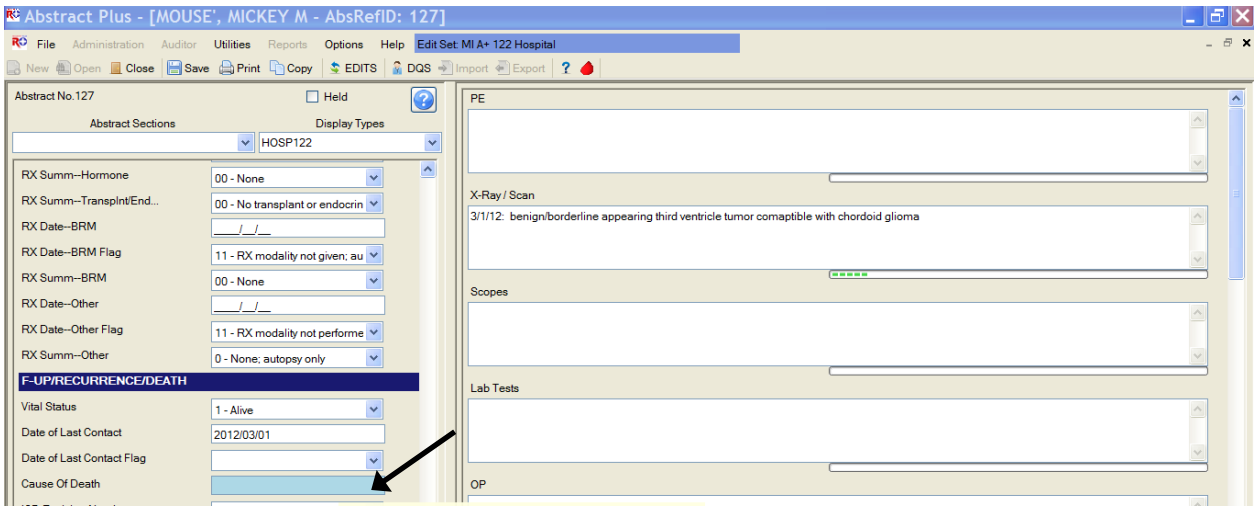


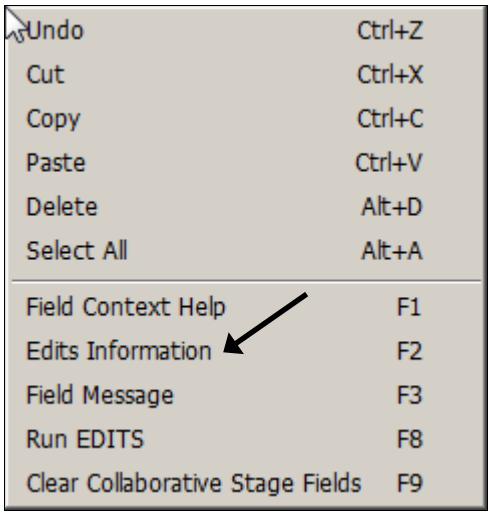
c. Edit errors can be viewed for the entire abstract, or just for individual fields. You can view **all edit errors** for the abstract as shown above by clicking on the EDITS icon on the toolbar, 

right-clicking and selecting **Run Edits**, **Save** icon 

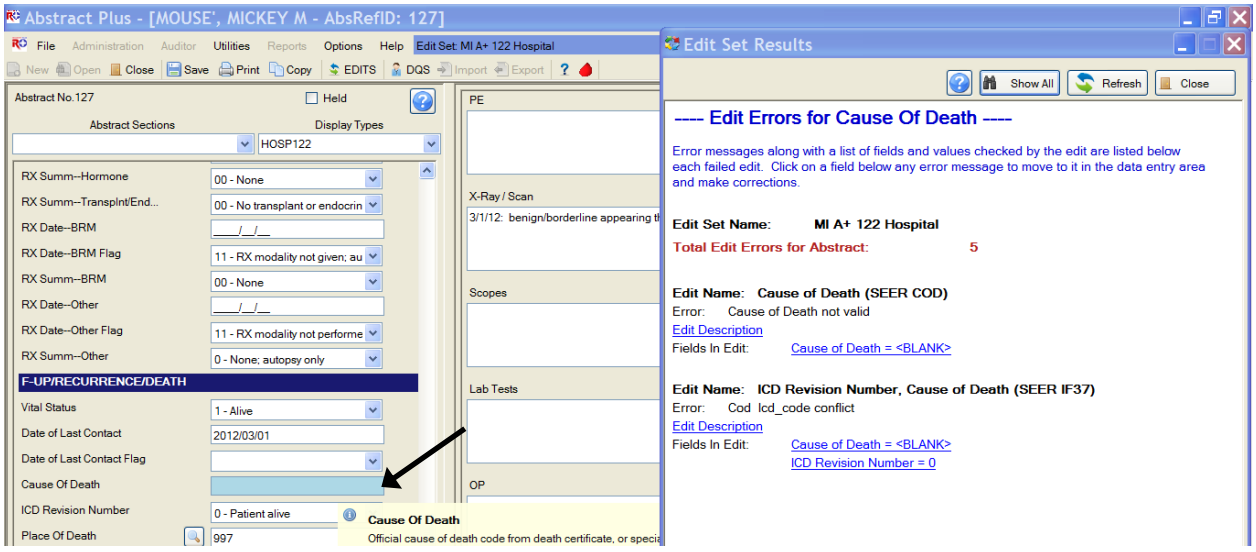
on the menu bar, or **pressing F8.**

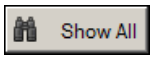
Or you can choose to view **edit errors by individual data field** by right-clicking and selecting **Edits Information,** or by **pressing F2.** In the example shown, right-click on the Cause of Death field to view the individual edit errors for Cause of Death, and click on Edits Information.



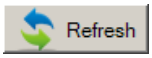


Result: In the Example shown, the edit errors for the individual data field Cause of Death are being viewed.



When viewing edit errors for an individual field, you can **switch** from the individual data field edit errors view to the all edit errors view by clicking on the **Show All** 

button.

You can make corrections to fields by clicking on the links to the fields in the Edit Set Results windows. To see your corrections reflected, click the **Refresh** 

button.

Completing Abstracts

As mentioned, you must resolve all edit errors and fill in all critical (required) fields in order to complete an abstract. Abstract Plus displays helpful, color-coded edits error count and abstract completion status information at the bottom of the abstracting window. Once you have resolved all edit errors and completed all missing critical fields, upon the next save of the abstract, the status information changes from red to green upon completion of the abstract.

Incomplete abstract containing edit errors:

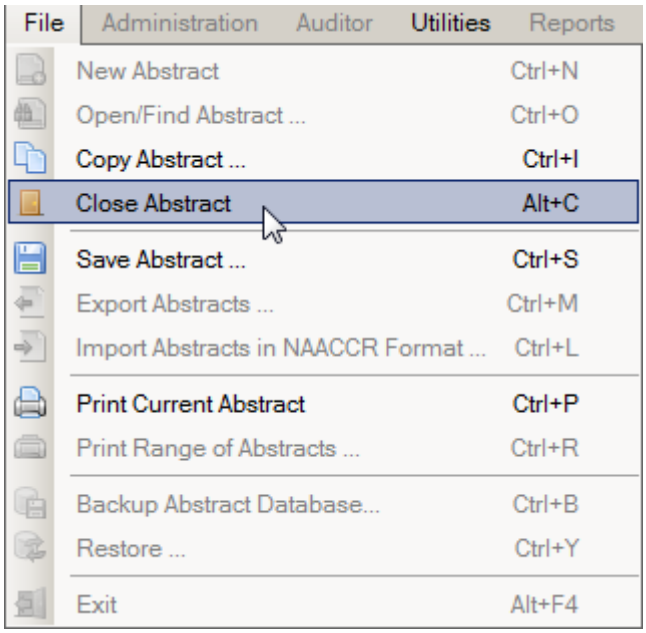
Complete abstract containing no edit errors:

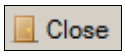
Closing Abstracts

Once you have entered information into an abstract and saved your work, you can close the abstract and open it in the future to complete your work. You can also search for an open completed abstracts.

To close an abstract, complete these steps.

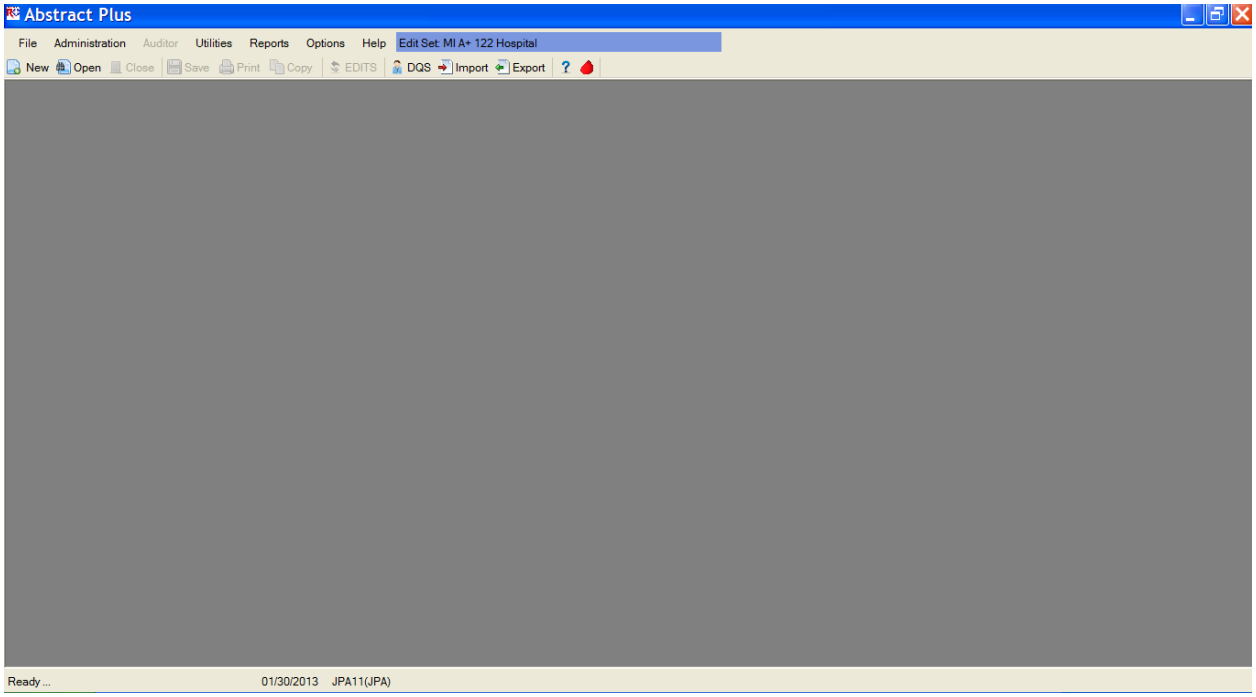
1. Abstracts can be closed in three ways.
    a. Click on the **File** menu, and select **Close Abstract**.



b. Click the **Close** icon on the tool bar. 

c. Use the keystroke **Alt+C**.

Result: The abstract is closed, and you are returned to the Abstract Plus main window.



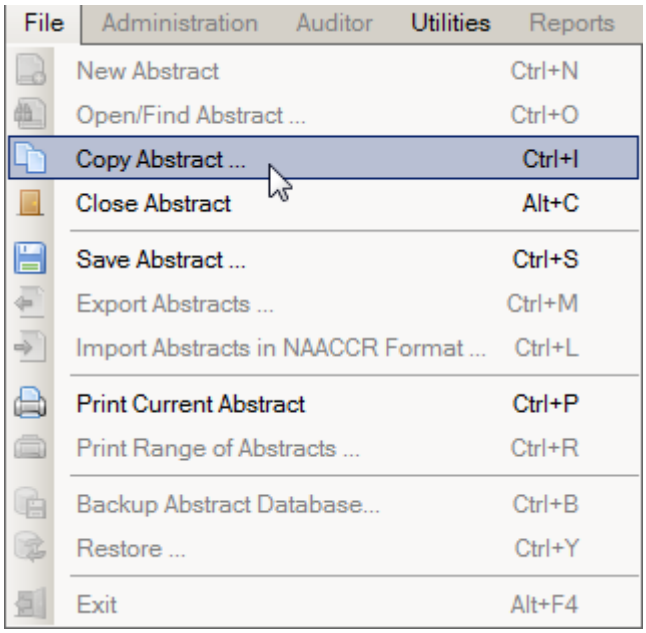
Close the abstract.

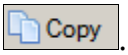
Copying an Abstract

The copy feature is especially helpful for the reporting of patients with multiple primaries. Simply open the abstract for the first primary for the patient, copy the abstract, and then enter the tumor and treatment information for the subsequent primary tumor.

To copy an abstract, complete these steps:

1. Make sure that you have the abstract to be copied open in the abstracting window.
2. Abstracts can be copied in three ways.
   a. Click on the **File** menu, and select **Copy Abstract**.



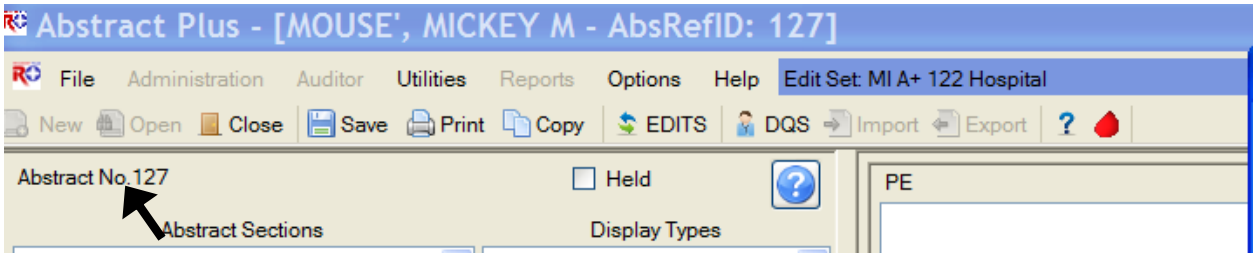
   b. Click the **Copy** icon on the tool bar 

.

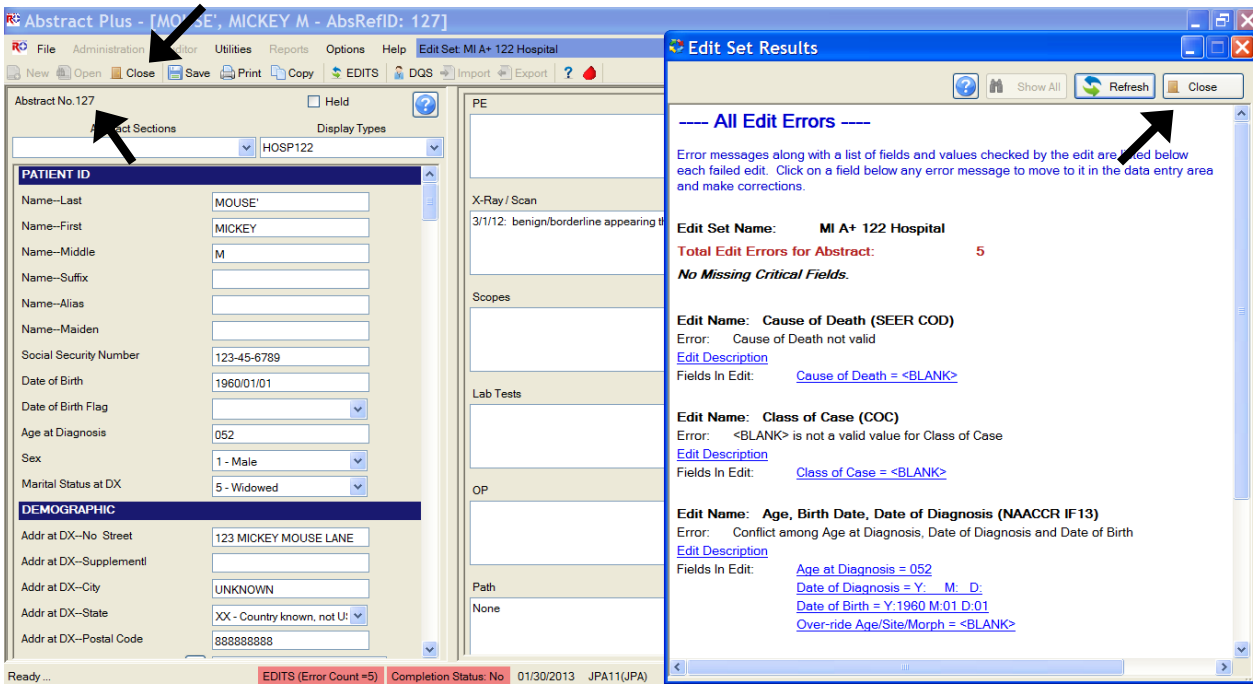
   c. Use the keystroke **Ctrl+I**.

Result: The abstract is copied to a new Abstract Reference ID. Note that the patient demographics from the original abstract are copied into the new abstract, so that you need only enter information regarding the new tumor being abstracted. Edits are run, and the Edit error count and completion status indicators will indicate that there are errors (missing fields) for the abstract and that the abstract is incomplete.

If the patient lives at a new residence for the subsequent primary tumor being reported, the primary address at the time of diagnosis must be updated to reflect the new primary tumor being reported. Do **not** update the address for the first primary.



3. Once you have finished work on the newly copied abstract, **save** your work, and **close** the abstract.



a. If you find an abstract that looks very much like an abstract you want to create, for example, the same patient but with a different diagnosis, you can simply save the abstract as a new one, and then modify the necessary fields in the new abstract.

Chapter 5: Exiting Abstract Plus, Backup and Restore Option

Learning Objectives

In this chapter, you will learn:

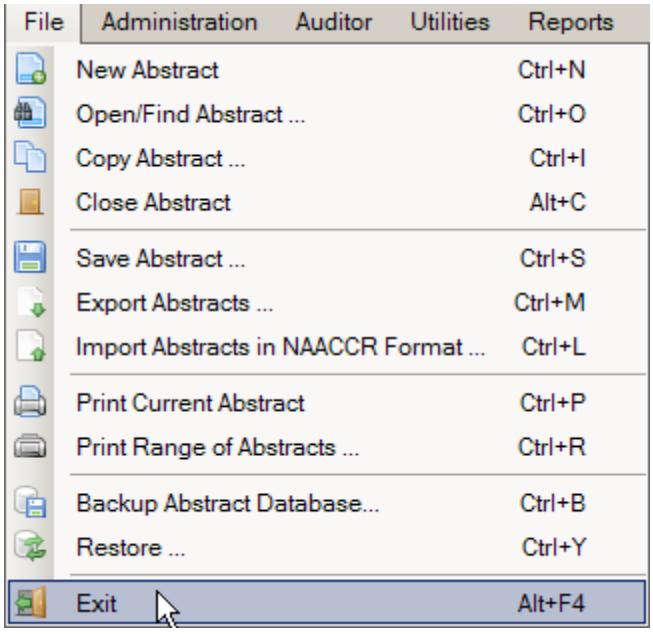
- How to log off and exit Abstract Plus
- To backup your current database
- How to restore your database if corrupted using the restore option

Exiting Abstract Plus and Backup Option

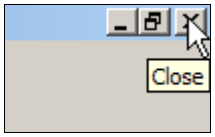
When logging off and exiting Abstract Plus, the application will prompt you to back up the current abstract database.

To log off / exit Abstract Plus and use the database backup option, complete these steps.

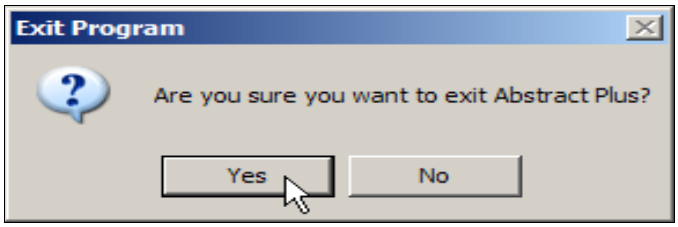
1. Exit Abstract Plus. This can be done in three ways.
    a. Click on the **File** menu, and select **Exit.**



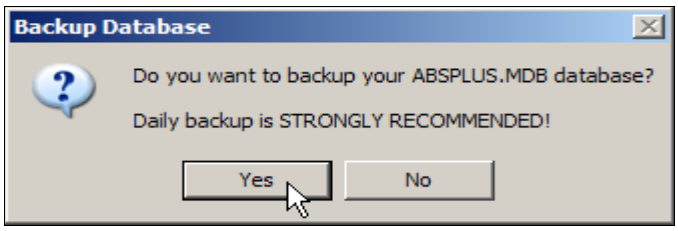
    b. Use the keystroke **Alt+F4.**
    c. Click the **X** in upper right corner of screen.



Result: The **Exit Program** window opens, and asks if you are sure you want to exit the program.



2. Click **Yes**.
Result: The **Backup Database** window opens, and asks if you would like to backup your Abstract Plus abstracts database (ABSPLUS.MDB).

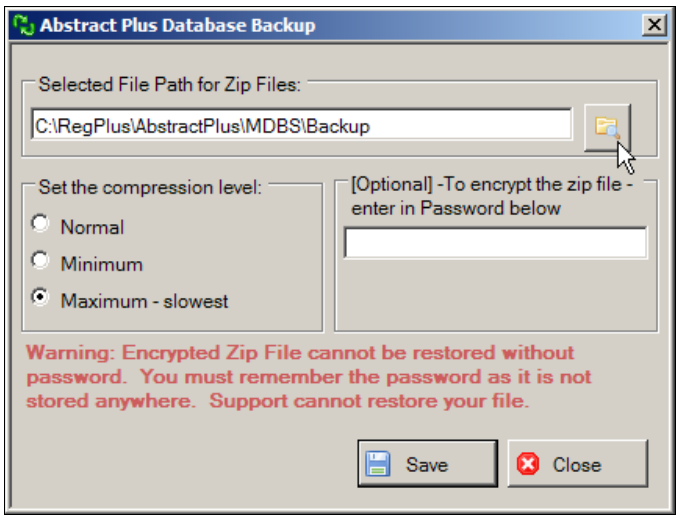


Important

Although you can choose not to back up your database, it is **highly recommended** that you back up your database after finishing an abstracting session during which changes were made (abstracts were added, updated, or deleted). Note that the Backup and Restore Database menu options **are not available when using SQL Server database**.

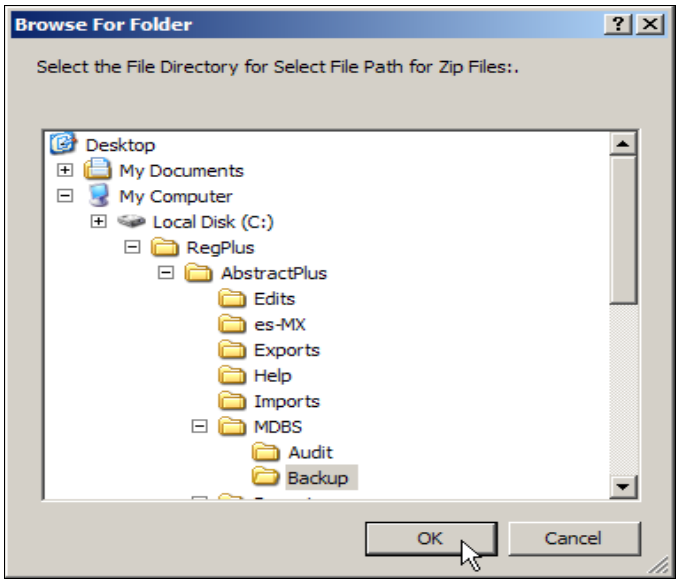
3. Click **Yes**.

Result: The **Abstract Plus Database Backup** window opens with defaults set.



4. To change the default path, navigate to and identify the location on your computer or network where you would like to save your backup file by clicking the **Folder** icon. 

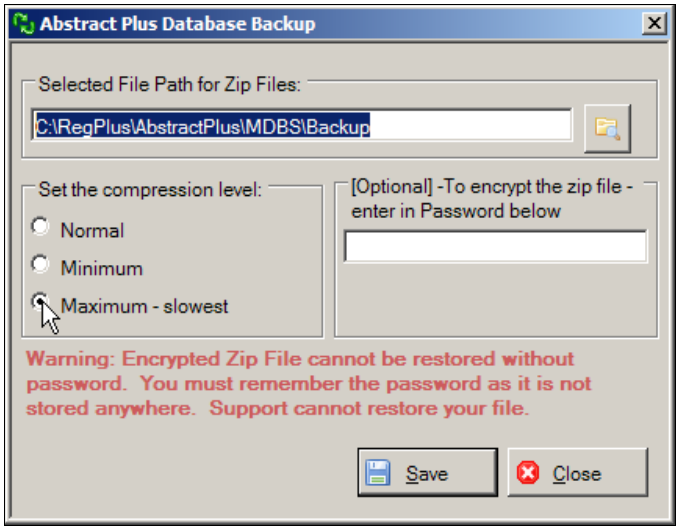
   Result: The **Browse for Folder** window opens.



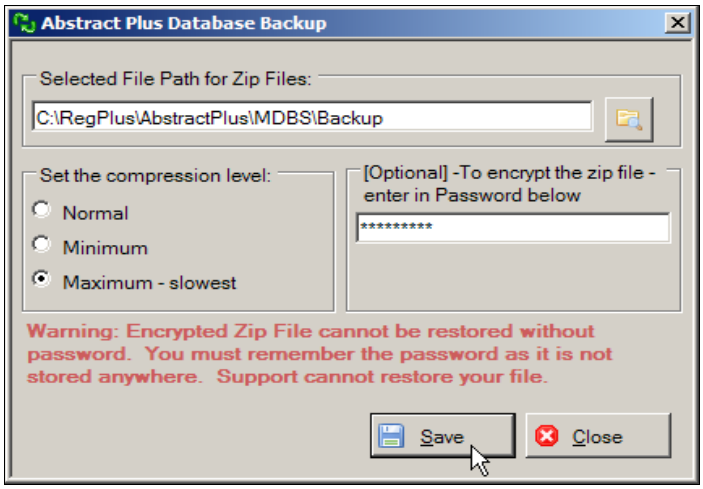
The default location for saving backup files is C:\RegPlus\AbstractPlus\MDBS\Backup; however, you may navigate to a different location if you so choose.

5. To accept the default location for saving the backup, click **OK**.

6. Select the desired **compression level** for the zip file if other than the default.



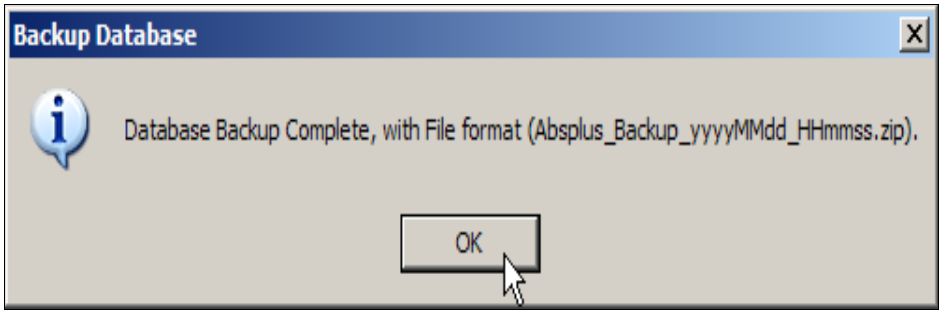
7. Enter a **password** (optional) to encrypt the zip file. Click **Save** to create the backup and exit or click **Close** to exit the application without saving the backup file.



Important

If you choose to password-protect your backup file, the encrypted zip file **cannot** be restored without the specified password. It is very important that you remember this password!

Result: The backup is saved in the zip file, and a confirmation window opens.



Note A progress bar is also displayed at the bottom of the screen.

8. Click **OK.**

   Result: The Abstract Plus application **closes**.

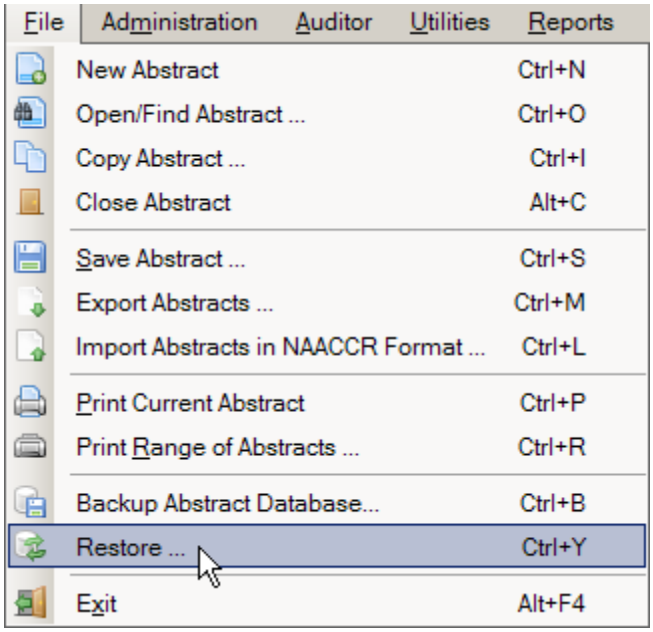
Restore Option

In the event that your Abstract Plus database (ABSPLUS.MDB) is corrupted, if you have used the Backup option to back up your database you will be able to restore your database using the Restore option. The Restore option allows you to go back to a file that you saved with the same Abstract Plus on a date when you encountered no problems. This is why it is strongly recommended that you back up your work when exiting the application.

To use the Restore option to restore your Abstract Plus abstract database to an earlier saved backup, complete these steps.

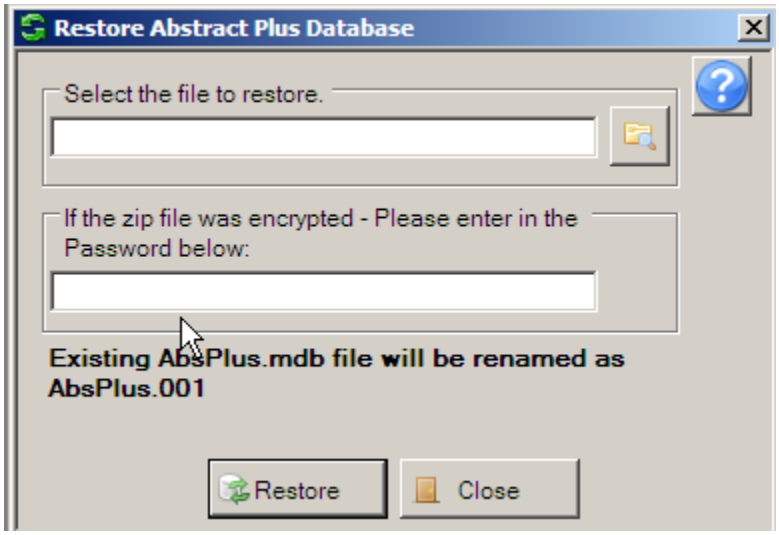
Open the Restore Database window. This can be done in two ways.

a. Click on the **File** menu, and select **Restore**.



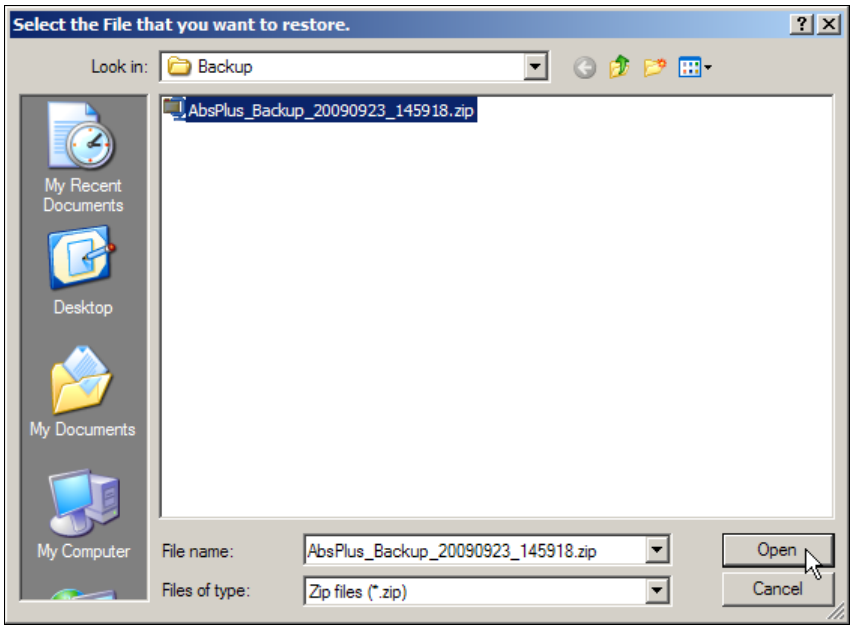
b. Use the keystroke **Ctrl+Y**.

Result: The **Restore Abstract Plus Database** window opens.



2. Navigate to and identify the zipped backup file on your computer or network by clicking the **Folder** icon.

Result: The **Select the file you want to restore** window opens with a list of backup files displayed.

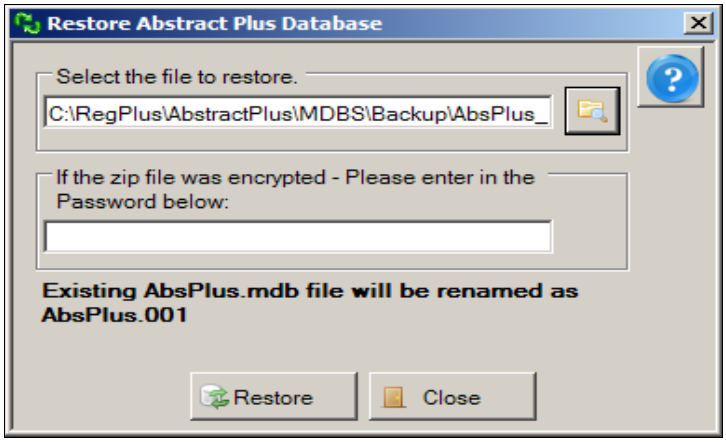


Note

The default location for saving backup files is C:\RegPlus\AbstractPlus\MDBS\Backup; however, you may need to navigate to a different location if you saved your backup file in a location other than the default location.

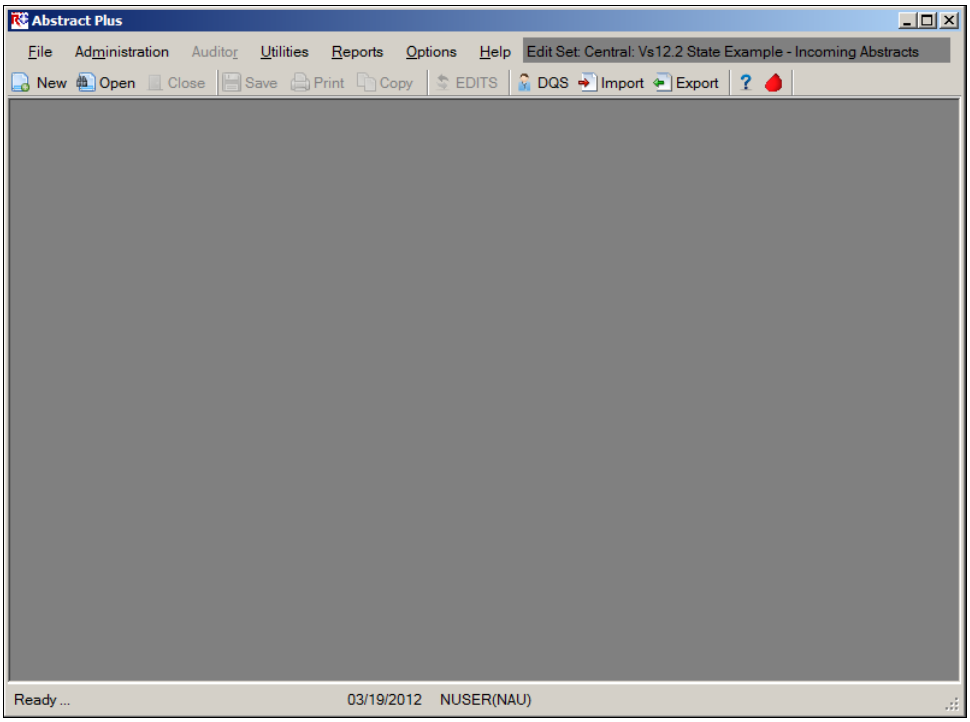
3. Select the backup file to which you wish to restore your Abstract Plus abstract database, and click **Open**.

   Result: You are returned to the **Restore Abstract Plus Database** window, with the selected backup file displayed.



4. If you password protected the selected backup file, enter the password in the password box, and click **Restore**.

   Result: The Abstract Plus main window opens, with the selected abstracts backup database restored. You may now resume abstracting activities.


Abstract Plus
File
Administration
Auditor
Utilities
Reports
Options
Help
Edit Set: Central: Vs12.2 State Example - Incoming Abstracts
New
Open
Close
Save
Print
Copy
EDITS
DQS
Import
Export
Ready ...
03/19/2012
NUSER(NAU)

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Chapter 6: Find/Open an Existing Abstract

Learning Objectives

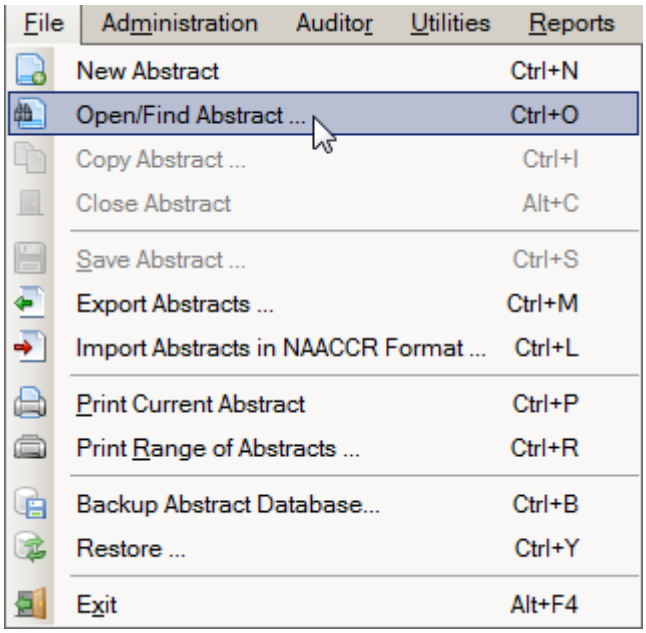
In this chapter, you will learn:

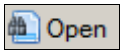
- How to find and open an existing abstract

Find and Open an Existing Abstract

To find and open an existing abstract, complete these steps.

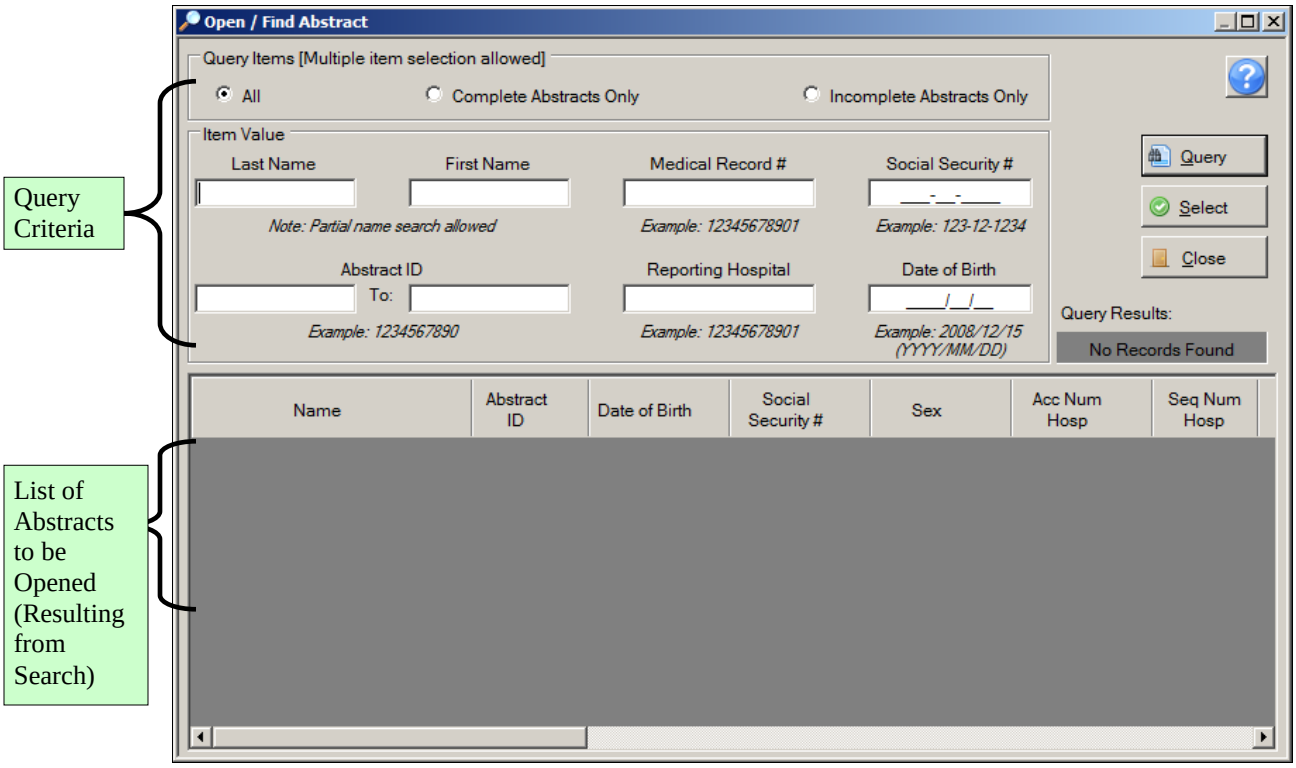
1. Existing abstracts can be searched for and opened in three ways.
    a. Click on the **File** menu, and select **Open/Find Abstract**.



    b. Click the **Open** icon on the tool bar. 

    c. Use the keystroke **Ctrl+O**.

Result: The **Open/Find Abstract** window opens.



The Open/Find Abstract window has two main sections. The **patient query area** is located in the upper portion of window, and the lower portion of the window displays the query results as a list of abstracts from which the abstract of interest can be opened. Abstracts listed can be queried by any combination of patient first name, patient last name, medical record number, social security number, date of birth, reporting hospital, or Abstract Reference ID. In addition, abstracts can be queried by abstract completion status by clicking on the appropriate search option at the top of the window.

If you click the Incomplete Abstracts Only search criteria option, only abstracts for which abstraction has not yet been completed will be displayed; this is very helpful for identifying abstracts that you have to complete.

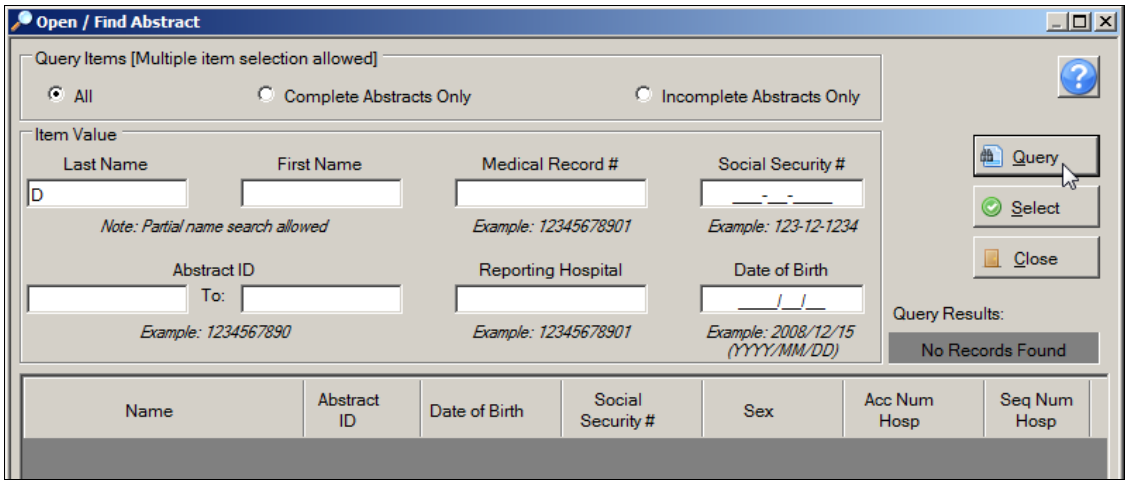
The abstract list window includes these fields and column headings.

Columns	Description
Name	Name of Patient (Last, First)
Abstract ID	A system-generated number identifying the abstract
Date of Birth	Patient's date of birth
Social Security #	Patient's social security number
Sex	Patient's sex

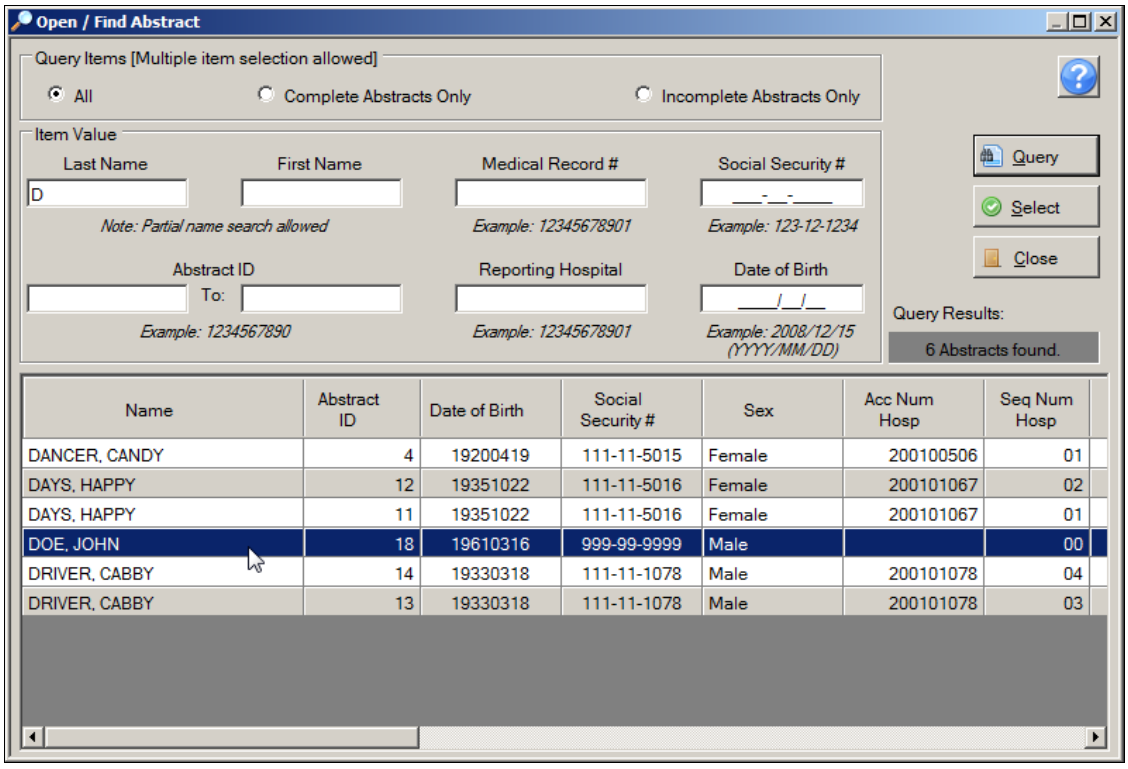
Columns	Description
Acc Num Hosp	Hospital accession number reported by the audited facility for the reported tumor
Seq Num Hosp	Sequence number hospital reported by the audited facility for the reported tumor
Date 1st Contact	Date of 1st contact reported by the audited facility for the reported tumor
Diagnosis Date	Diagnosis date of the reported tumor
Primary Site	ICD-O-3 topography code describing the location of the reported tumor
Reporting Hospital	COC code for the reporting facility that reported the tumor
Laterality	Code for the side of a paired organ, or the side of the body on which the reported tumor originated
Hist/Beh ICDO3	ICD-O-3 histology and behavior codes for the reported tumor
Medical Record #	Patient's medical record number
Date Last Contact	Date last contact reported by the audited facility for the reported tumor
Vital Status	Patient's vital status
Abstract Status	The status of the reabstract---incomplete, complete, or held

The order of the columns on the abstract list window may be modified. Simply left-click and hold on the column header, and slide the column to the desired position in the column viewing order.

2. Query for a patient on the list of tumors to be opened. Enter the **first letter** of the patient's **last name** in the **Last Name search criteria** box on the Open/Find Abstract window, and click **Query**. You can also use any of the other available search criteria to search upon. In the example shown, the abstract being searched for is for a patient named John Doe, so a **D** is entered in the Last Name search criteria box.

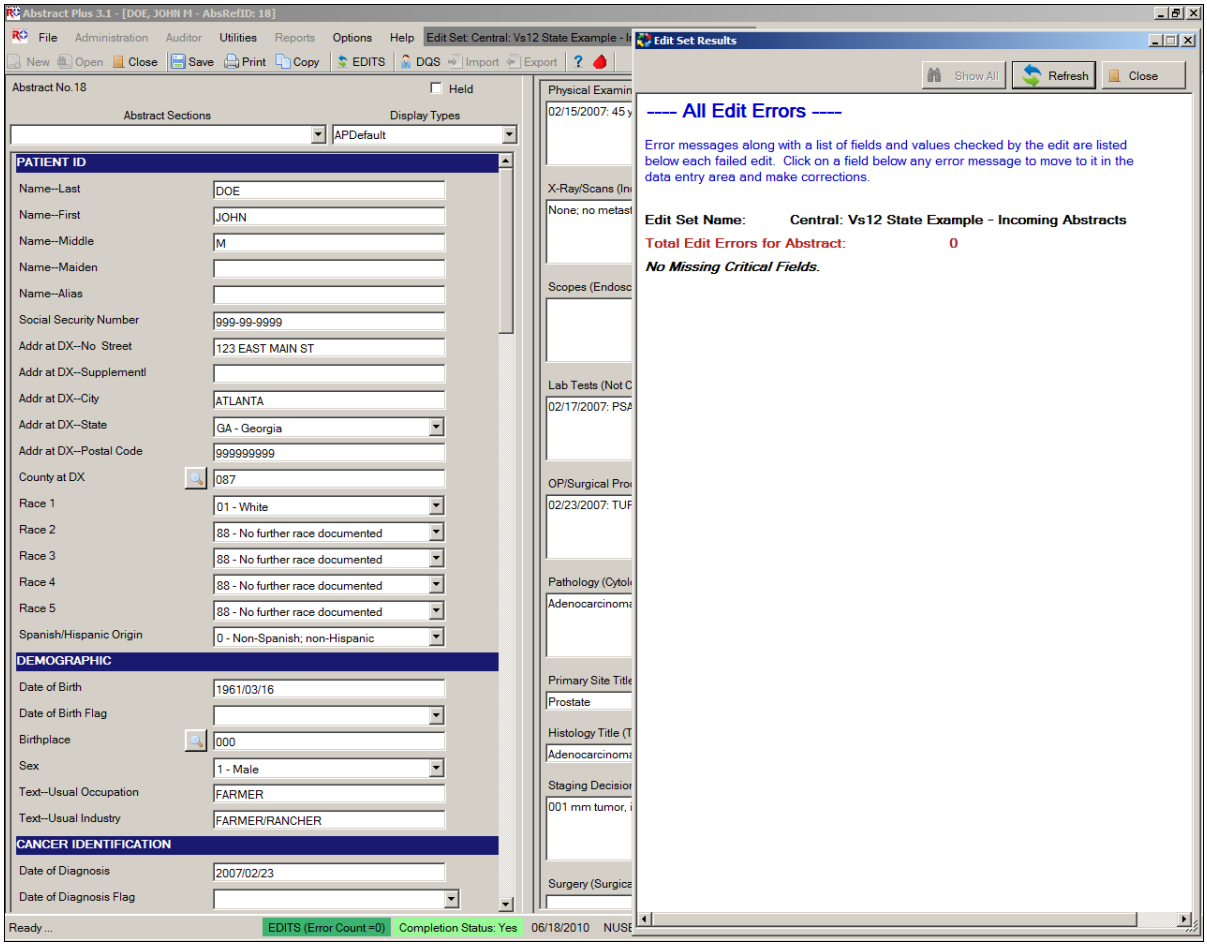


Result: The Open/Find Abstract window presents the results of the query, and displays any **potential matches** in the tumor list window.



3. From the abstracts listed, locate the abstract of interest **open the abstract,** either by **double-clicking** the row for the abstract, or select the row for the abstract and click **Select**.

   Result: The **Abstract Plus Abstracting** window opens so that you can modify the abstract that has just been opened.


Abstract Plus 3.1 - [DOE, JOHN M - AbsRefID: 18]
File Administration Auditor Utilities Reports Options Help
New Open Close Save Print Copy EDITS DQS Import Export
Abstract No.18
Held
Abstract Sections
Display Types
APDefault
PATIENT ID
Name--Last DOE
Name--First JOHN
Name--Middle M
Name--Maiden
Name--Alias
Social Security Number 999-99-9999
Addr at DX--No Street 123 EAST MAIN ST
Addr at DX--Supplementl
Addr at DX--City ATLANTA
Addr at DX--State GA - Georgia
Addr at DX--Postal Code 999999999
County at DX 087
Race 1 01 - White
Race 2 88 - No further race documented
Race 3 88 - No further race documented
Race 4 88 - No further race documented
Race 5 88 - No further race documented
Spanish/Hispanic Origin 0 - Non-Spanish; non-Hispanic
DEMOGRAPHIC
Date of Birth 1961/03/16
Date of Birth Flag
Birthplace 000
Sex 1 - Male
Text--Usual Occupation FARMER
Text--Usual Industry FARMER/RANCHER
CANCER IDENTIFICATION
Date of Diagnosis 2007/02/23
Date of Diagnosis Flag
Physical Examin
02/15/2007: 45 y
X-Ray/Scans (In
None; no metast
Scopes (Endosc
Lab Tests (Not C
02/17/2007: PSA
OP/Surgical Pro
02/23/2007: TUF
Pathology (Cytol
Adenocarcinoma
Primary Site Title
Prostate
Histology Title (T
Adenocarcinoma
Staging Decisior
001 mm tumor,
Surgery (Surgica
Ready ...
EDITS (Error Count =0)
Completion Status: Yes
06/18/2010
Edit Set Results
Show All
Refresh
Close
---- All Edit Errors ----
Error messages along with a list of fields and values checked by the edit are listed below each failed edit. Click on a field below any error message to move to it in the data entry area and make corrections.
Edit Set Name: Central: Vs12 State Example - Incoming Abstracts
Total Edit Errors for Abstract: 0
No Missing Critical Fields.

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Chapter 7: Exporting Abstracts

Learning Objectives

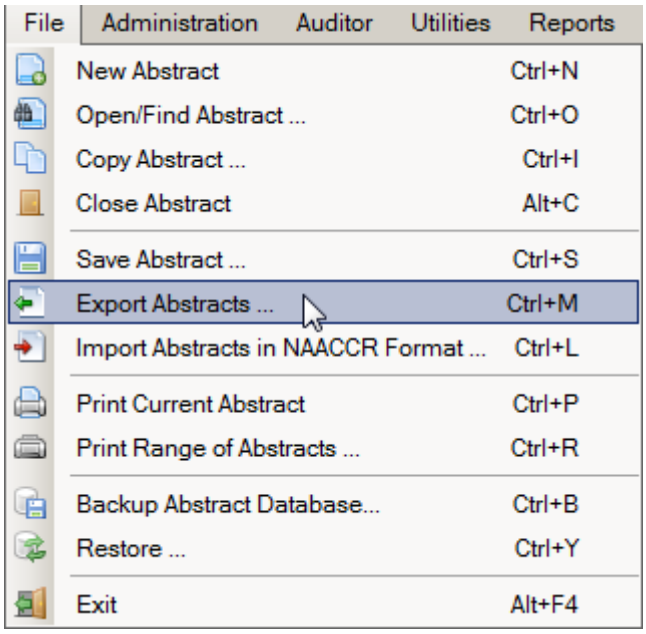
In this chapter, you will learn:

- How to Export abstracts
- How to verify the number of cases expected to be exported
- How to preview the export selection
- How to enter a file name and save an export file
- How to preview and print a report

Export Abstracts

To export abstracts, complete these steps.

1. Abstracts can be exported in three ways.
   a. Click on the **File** menu, and select **Export Abstracts**.

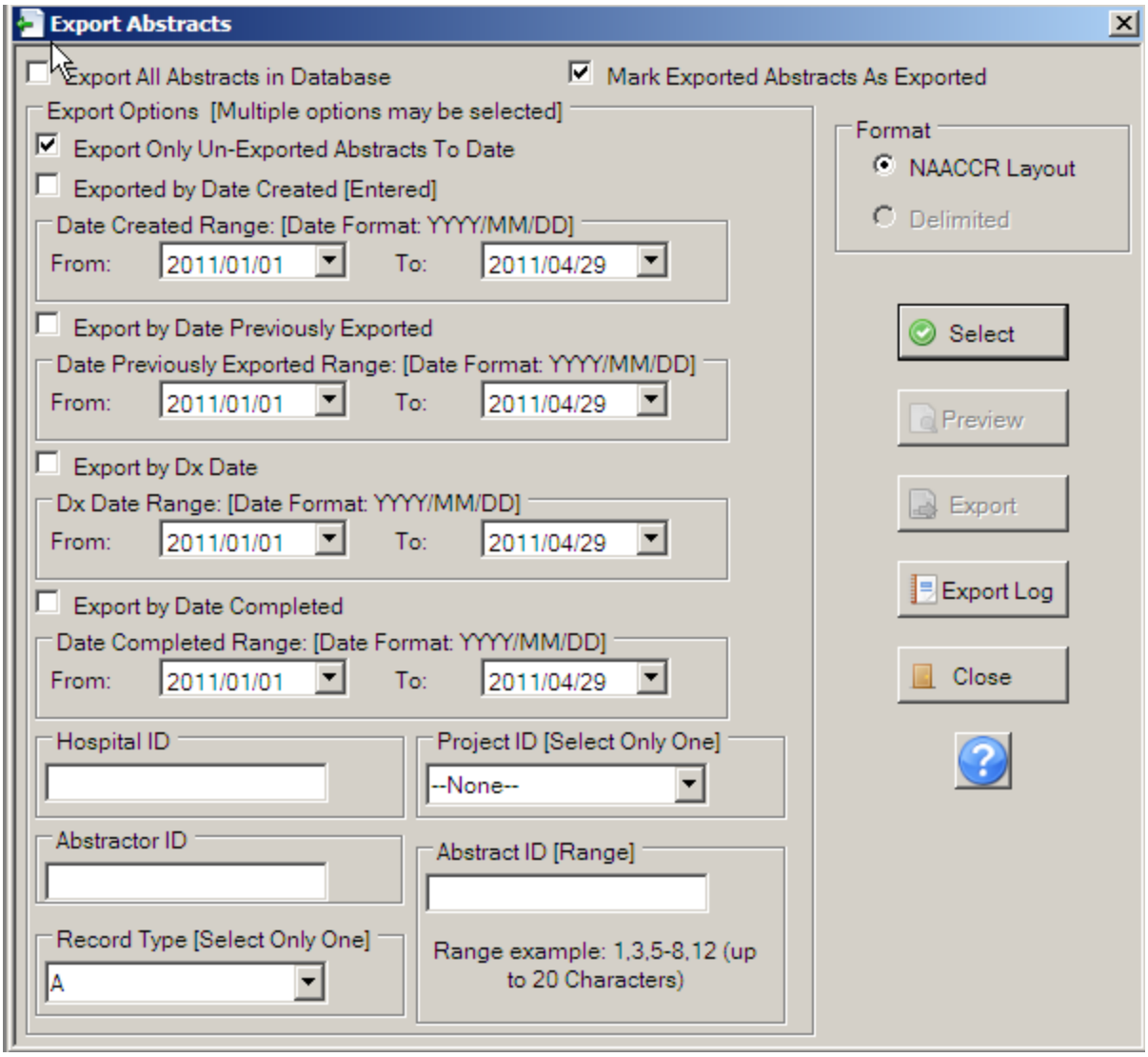


   b. Click the **Export** icon on the tool bar. 

   c. Use the keystroke **Ctrl+M**.

   Result: The **Export Abstracts** window opens.

The **Mark Exported Abstracts as Exported** and **Export Only Un-Exported Abstracts To Date** options are selected by default and, in general, should not be changed as these options will prevent re-export of previously exported abstracts, thus preventing reporting of duplicate abstracts to your central registry.

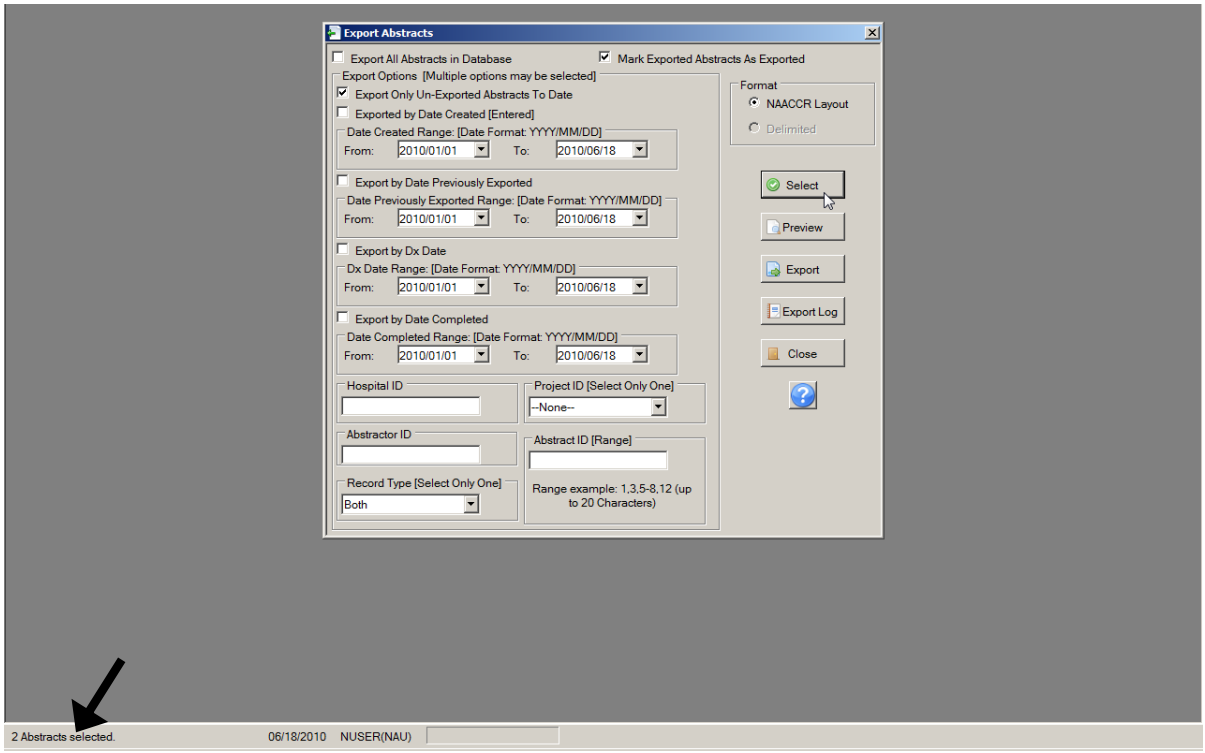


2. If the **Mark Exported Abstracts as Exported** is selected, go to Step 3.
   a. If not, select **Mark Exported Abstracts as Exported**.

3. If the **Export Only Un-Exported Abstracts To Date** is selected, go to Step 4.
   a. If not, select Export Only Un-Exported Abstracts To Date

4. Click on **Select**.

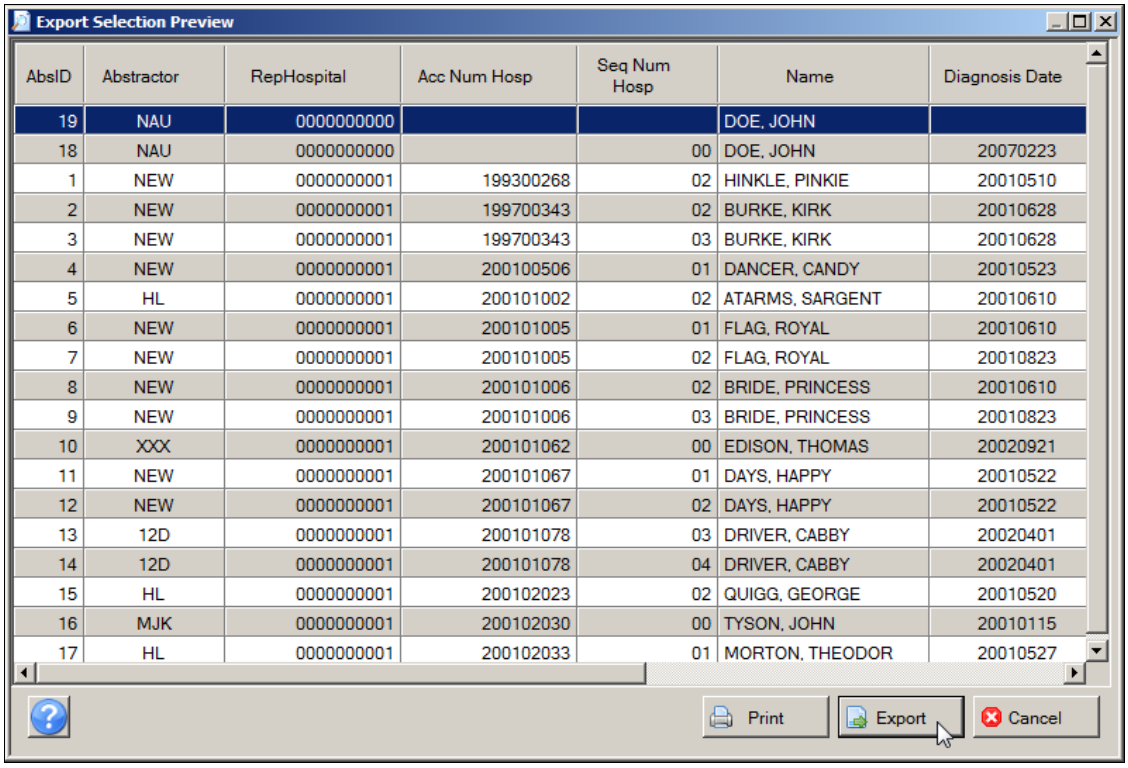
   Result: The system displays the number of abstracts that meet the export criteria and are to be exported in the lower left-hand corner of the main window.



5. Verify that the Number of Cases Selected shown at the bottom left corner of the main window is the number of cases exported to be exported.

6. If the numbers do not match, **click** on the **Preview** button.

   Result: The Export Selection Preview window opens.



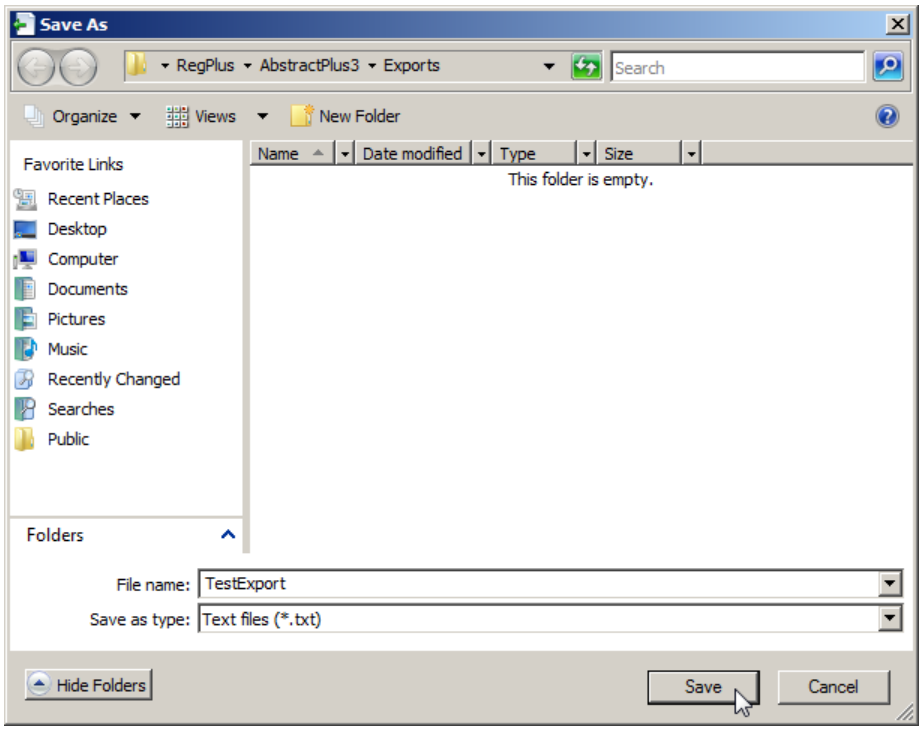
AbsID	Abstractor	RepHospital	Acc Num Hosp	Seq Num Hosp	Name	Diagnosis Date
19	NAU	0000000000			DOE, JOHN	
18	NAU	0000000000		00	DOE, JOHN	20070223
1	NEW	0000000001	199300268	02	HINKLE, PINKIE	20010510
2	NEW	0000000001	199700343	02	BURKE, KIRK	20010628
3	NEW	0000000001	199700343	03	BURKE, KIRK	20010628
4	NEW	0000000001	200100506	01	DANCER, CANDY	20010523
5	HL	0000000001	200101002	02	ATARMS, SARGENT	20010610
6	NEW	0000000001	200101005	01	FLAG, ROYAL	20010610
7	NEW	0000000001	200101005	02	FLAG, ROYAL	20010823
8	NEW	0000000001	200101006	02	BRIDE, PRINCESS	20010610
9	NEW	0000000001	200101006	03	BRIDE, PRINCESS	20010823
10	XXX	0000000001	200101062	00	EDISON, THOMAS	20020921
11	NEW	0000000001	200101067	01	DAYS, HAPPY	20010522
12	NEW	0000000001	200101067	02	DAYS, HAPPY	20010522
13	12D	0000000001	200101078	03	DRIVER, CABBY	20020401
14	12D	0000000001	200101078	04	DRIVER, CABBY	20020401
15	HL	0000000001	200102023	02	QUIGG, GEORGE	20010520
16	MJK	0000000001	200102030	00	TYSON, JOHN	20010115
17	HL	0000000001	200102033	01	MORTON, THEODOR	20010527

a. Using this report, verify all cases you expect to export meet the exporting criteria, verify the correct information is checked/entered on the Export screen and verify count of incompletes is correct. To close report, lick on the X in the upper right corner.

Preview can be used at any time to view the records selected for export.

7. If the numbers match, click **Export**.

   Result: The **Save As** window opens.

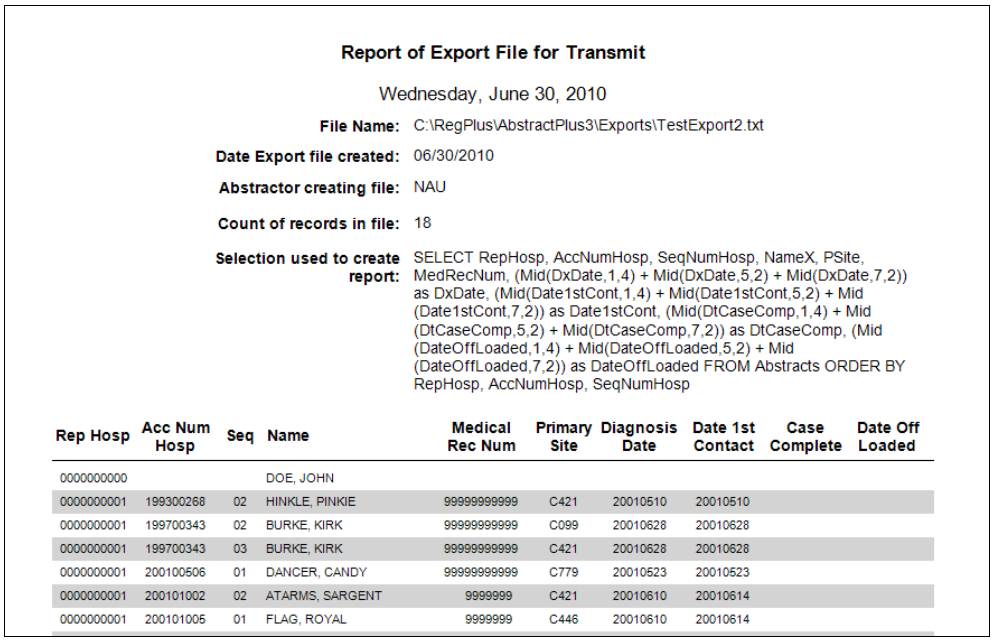


8. Enter a **file name** for the export file in the File name box. The file name must begin with **MI** followed by the **5-digit Michigan assigned facility number** that is part of your Userid. Next add the **date stamp (YYYYMMDD)**. For example, facility 33333 submitting a file created on April 28, 2012 will have the file name of **MI3333320120428**, along with whatever extension you might wish to add.

If you are sending more than one file at a time, please make sure that EACH file has a different extension added i.e.: -1, -2, -3, etc. on the file name. For example, the same facility could have the files MI3333320120428-1of3.txt, and so on.

9. Click on **Save**. In the example shown, the export file is being saved as TestExport.txt.

Result: The system saves the abstracts into a text file and lets you preview a report that you can print.



Report of Export File for Transmit

Wednesday, June 30, 2010

File Name: C:\RegPlus\AbstractPlus3\Exports\TestExport2.txt

Date Export file created: 06/30/2010

Abstractor creating file: NAU

Count of records in file: 18

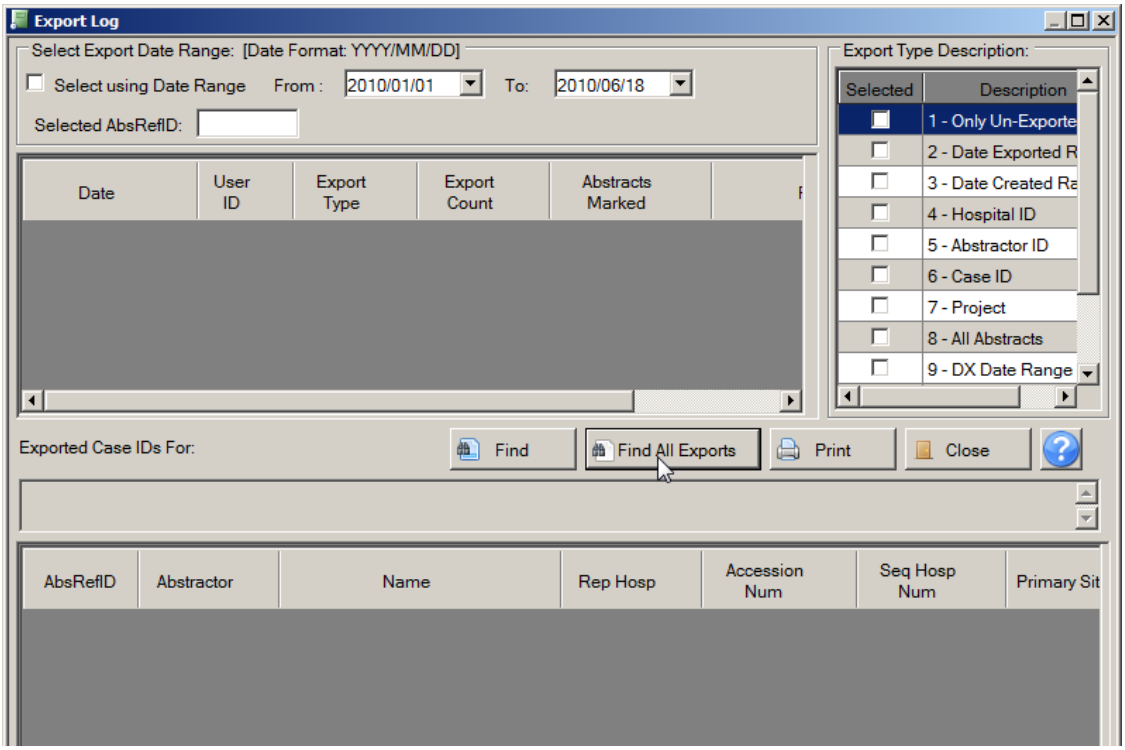
Selection used to create report: SELECT RepHosp, AccNumHosp, SeqNumHosp, NameX, PSite, MedRecNum, (Mid(DxDate,1,4) + Mid(DxDate,5,2) + Mid(DxDate,7,2)) as DxDate, (Mid(Date1stCont,1,4) + Mid(Date1stCont,5,2) + Mid (Date1stCont,7,2)) as Date1stCont, (Mid(DtCaseComp,1,4) + Mid (DtCaseComp,5,2) + Mid(DtCaseComp,7,2)) as DtCaseComp, (Mid (DateOffLoaded,1,4) + Mid(DateOffLoaded,5,2) + Mid (DateOffLoaded,7,2)) as DateOffLoaded FROM Abstracts ORDER BY RepHosp, AccNumHosp, SeqNumHosp

Rep Hosp	Acc Num Hosp	Seq	Name	Medical Rec Num	Primary Site	Diagnosis Date	Date 1st Contact	Case Complete	Date Off Loaded
0000000000			DOE, JOHN						
0000000001	199300268	02	HINKLE, PINKIE	99999999999	C421	20010510	20010510		
0000000001	199700343	02	BURKE, KIRK	99999999999	C099	20010628	20010628		
0000000001	199700343	03	BURKE, KIRK	99999999999	C421	20010628	20010628		
0000000001	200100506	01	DANCER, CANDY	99999999999	C779	20010523	20010523		
0000000001	200101002	02	ATARMS, SARGENT	9999999	C421	20010610	20010614		
0000000001	200101005	01	FLAG, ROYAL	9999999	C446	20010610	20010614		

10. **Close** the report preview and return to the Export Abstracts window.

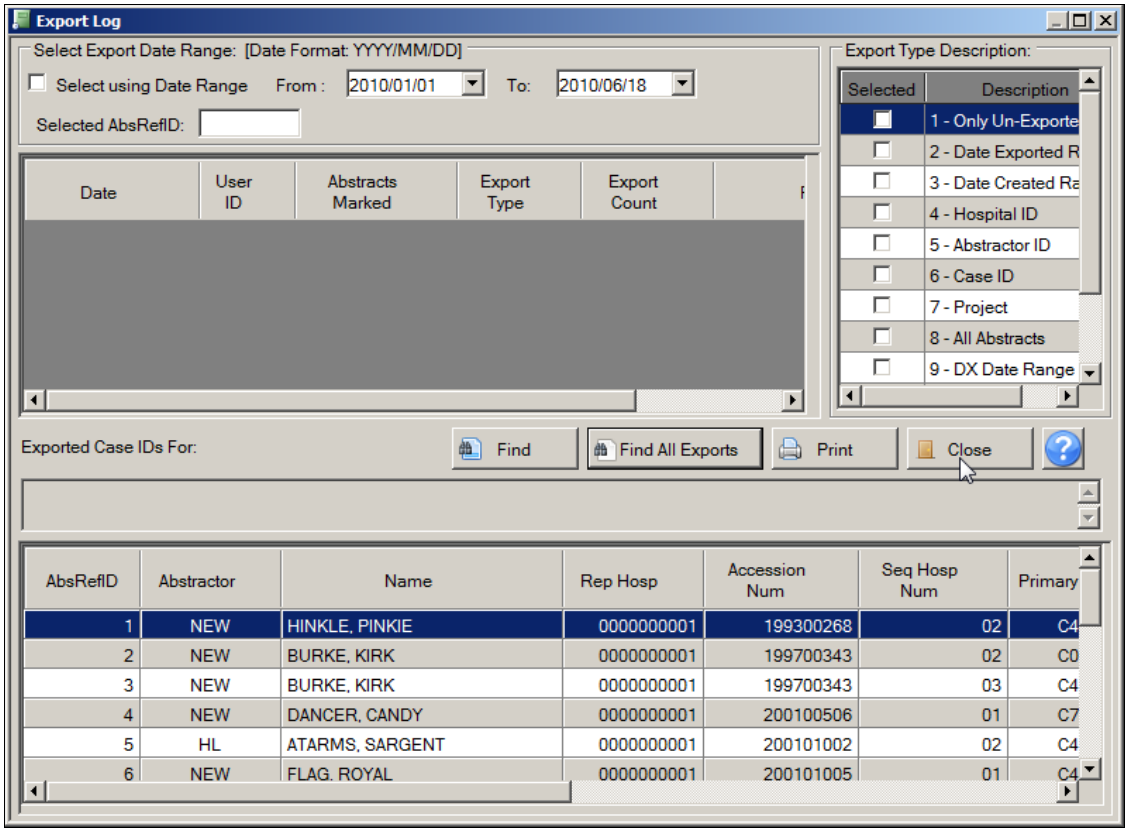
11. Click **Export Log** to view the log of exported abstracts.

    Result: The **Export Log** window opens. Notice that you can enter a date range or enter Select Case ID, and click **Select** to view exports that contain the specified values.



12. Enter an **export date range or** specific **AbsRefID**, and click **Find**, or click **Find All Exports** to view all exports in the log.

    Result: Specific fields for exported cases meeting the criteria entered are displayed in the lower window**.**



13. Click **Close** to return to the Export Abstracts window and **Close** to return to the main menu.

14. Go to **Submission of Data**, Chapter8.

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Chapter 8: Submission of Data

Learning Objectives

In this chapter, you will learn:

- How to submit an Export file to the Michigan Cancer Surveillance Program (MCSP)

Submission of Data Instructions

After completing the instructions for Exporting Abstracts, submit the Export file to the MCSP using the MCSP File Transfer Protocol (FTP) site, which is the fastest and most secure data transfer for submission of your data. The instructions are as follows.

1. File Transfer Protocol (FTP): To submit Exported Files using the FTP site, follow the instructions listed below.
   a. Go to DCH application portal at https://sso.state.mi.us and login using the SSO userid assigned to you by the MCSP.
   b. Click on DCH-File Transfer.
   c. Click on Upload File.
   d. Click on Browse button and select the directory/path and file name (*Exporting Procedure* step 8)
   e. The path and file name will show up on the box next to the Browse button.
   f. Click on Upload.
   g. Refer to instructions in the MCSP FileXFr User Manual.

NOTE: If you do not have an SSO account, please contact Terry McTaggart at 517/335-9624 or mctaggartT1@michigan.gov, or Won Silva at 517/335-9391 or silvaw@michigan.gov.

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Chapter 9: Printing Abstracts

Learning Objectives

In this chapter, you will learn:

- How to print an open abstract
- How to print a range of abstracts
- To preview a report before printing
- How to save a report

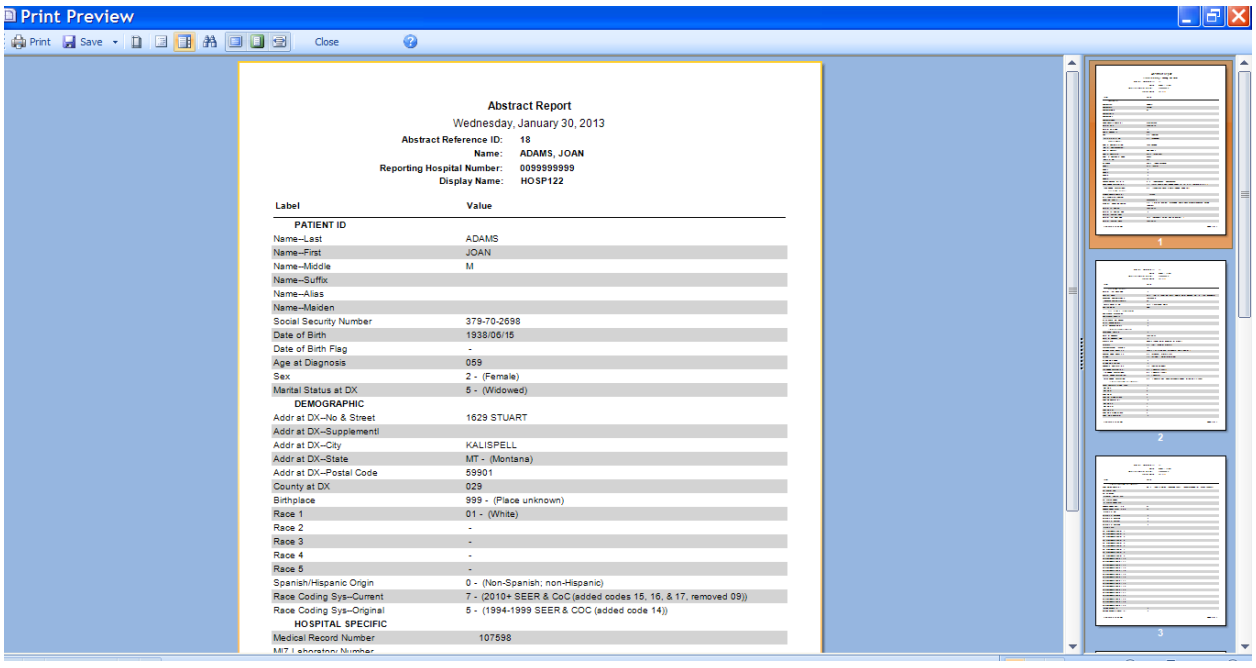
Printing an Open Abstract

To print an abstract that is open, complete these steps:

1. An opened abstract can be printed in three ways:
   a. Click on the **File** menu, and select **Print Current Abstract**.
   b. Click the **Print** icon on the tool bar 

.
   c. Use the keystroke **Ctrl+P**.

   Result: The Abstract Plus **Report Viewer** window opens with a print preview of the abstract to be printed. Note that for the majority of fields, the coded value and the label are printed. Please see page 152 of this manual or click here to learn more about using the Report Viewer window to view, save and print reports.



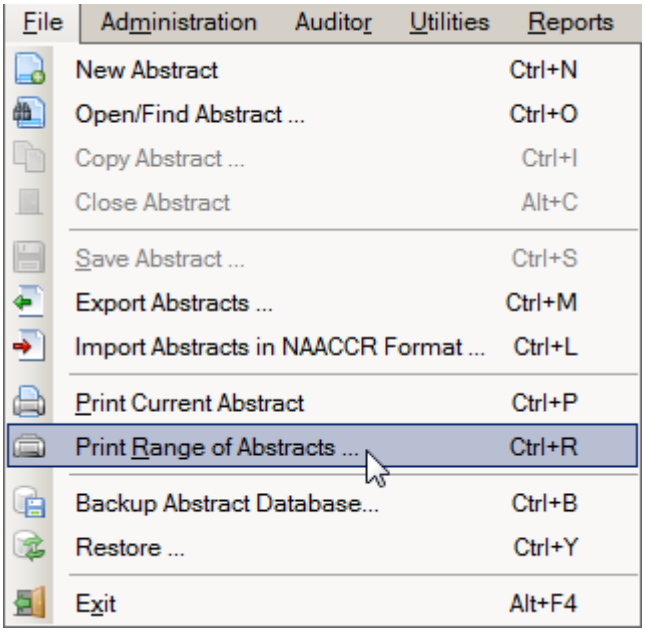
2. Click **Print** or **Save** to print or save the abstract in the format of your choice.

3. When you are done viewing/printing the abstract, click **Close**.

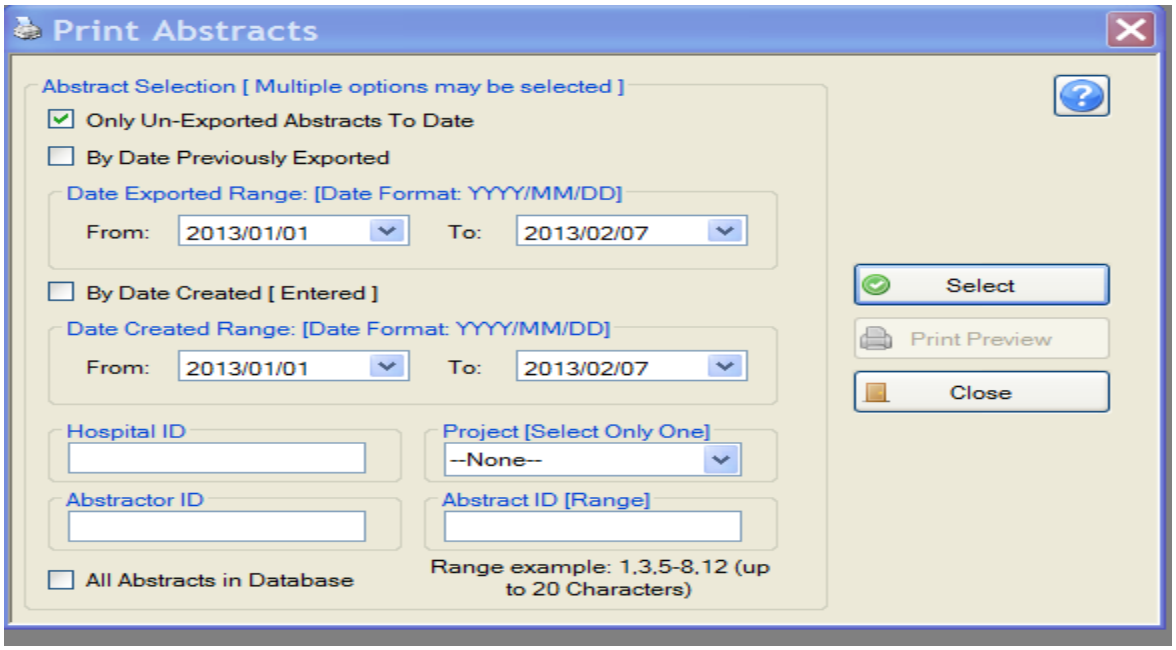
Printing a Range of Abstracts

To print a range of abstracts, complete these steps.

1. Printing a range of abstracts can be done in two ways.
   a. Click on the **File** menu, and select **Print Range of Abstracts**.
   b. Use the keystroke **Ctrl+R**.



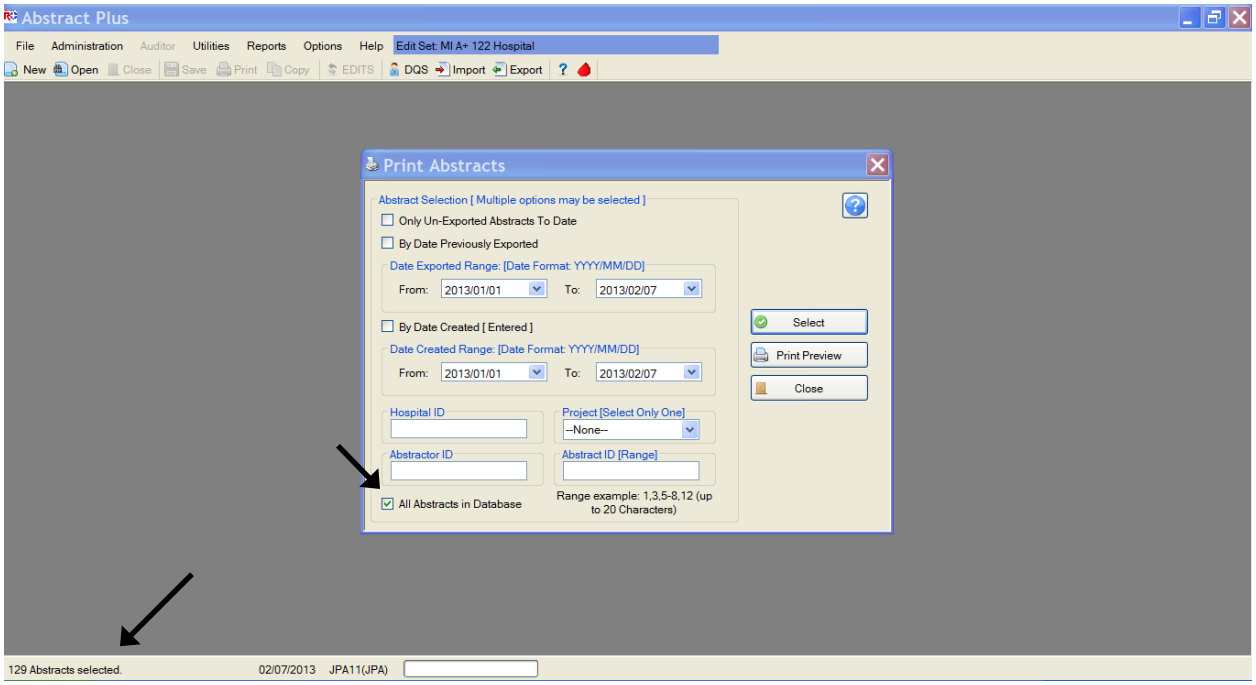
Result: The **Print Abstracts** window opens.



2. Enter the abstract selection criteria for the range of abstracts that you would like to print. You can select the only un-exported Abstracts To Date or All Abstracts in Database options, or you can select abstracts by date previously exported, date created, Facility or Project ID, Abstractor ID or AbsRefID. In the example shown the Select the All Abstracts in Database printing option is checked.

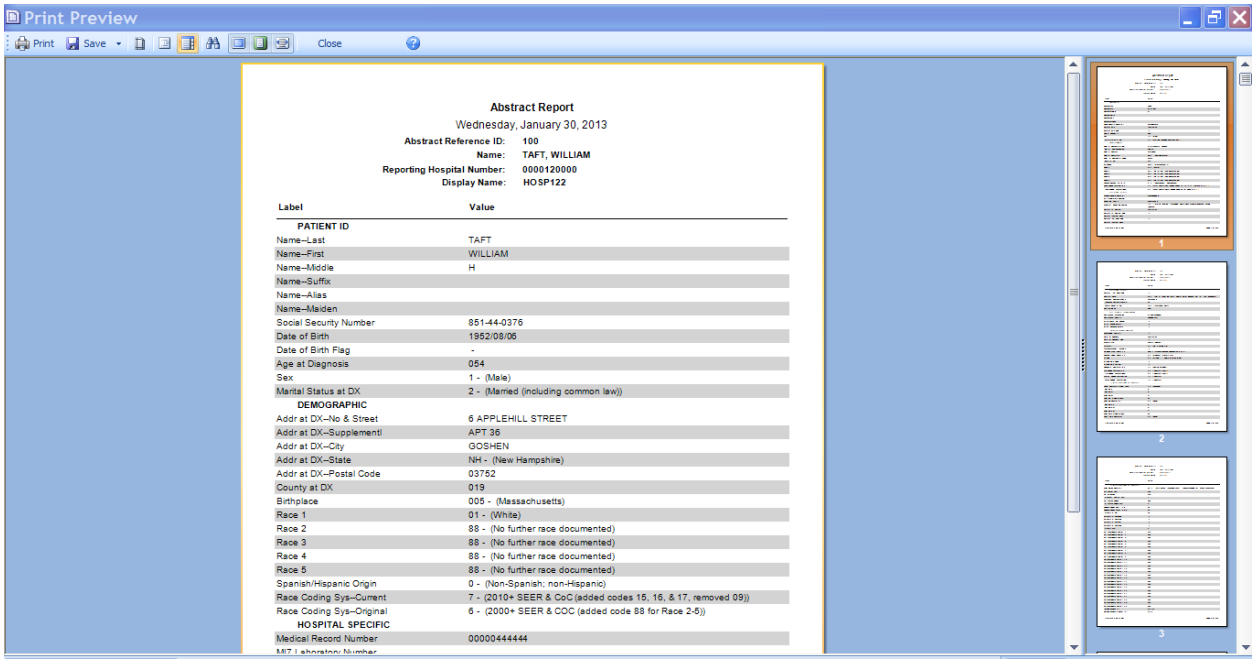
3. Click **Select**.

   Result: The system displays the number of abstracts that meet the selected criteria at the bottom of the window.



4. Click **Print Preview**.

   Result: The **Report Viewer** window opens with the selected abstracts formatted for printing.



5. When you are done viewing the report, click **Print** to print the report and **Save** to save the report.

6. Click **Close** to close the report.

7. **Close** the Print Abstracts window.

Chapter 10: Deleting Abstracts

Learning Objectives

In this chapter, you will learn:

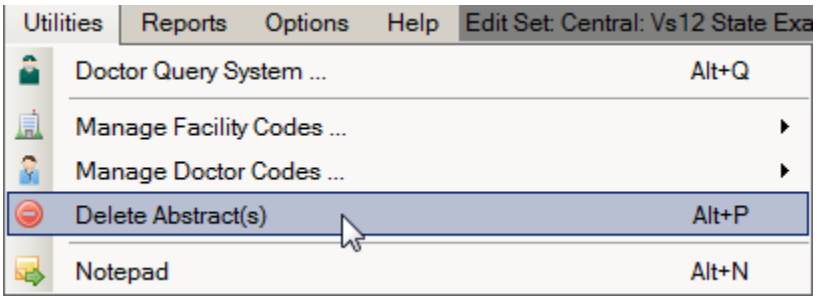
- How to delete an abstract from the abstract database

Delete an Abstract

Abstract Plus version 3.2.1.0 allows you to delete abstracts from the abstract database. This feature should be used with caution, as abstracts are permanently deleted from the database.

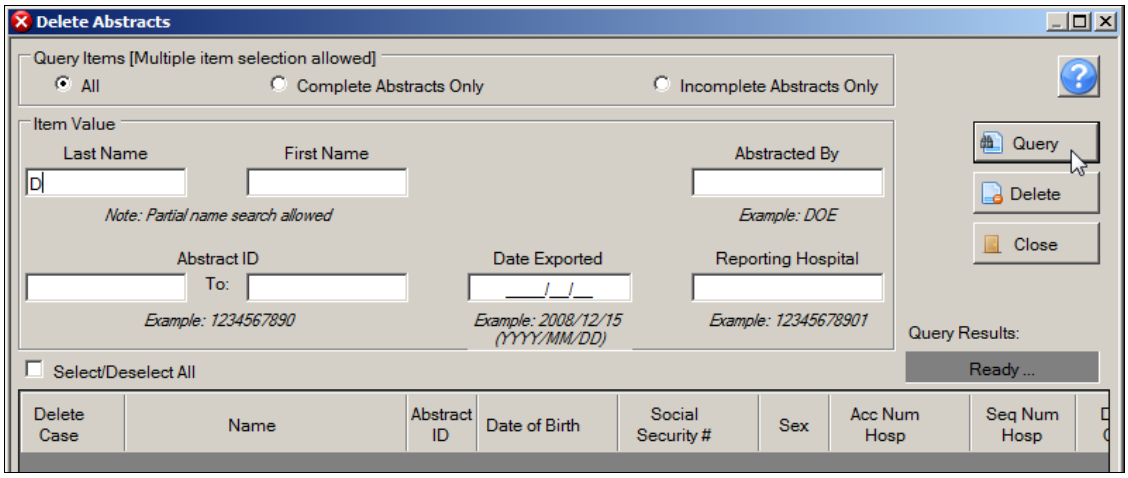
To delete an abstract, complete these steps.

1. Abstracts can be deleted in two ways.
   a. Click on the **Utilities** menu, and select **Delete Abstract(s)**.



   b. Use the keystroke **Alt+P**

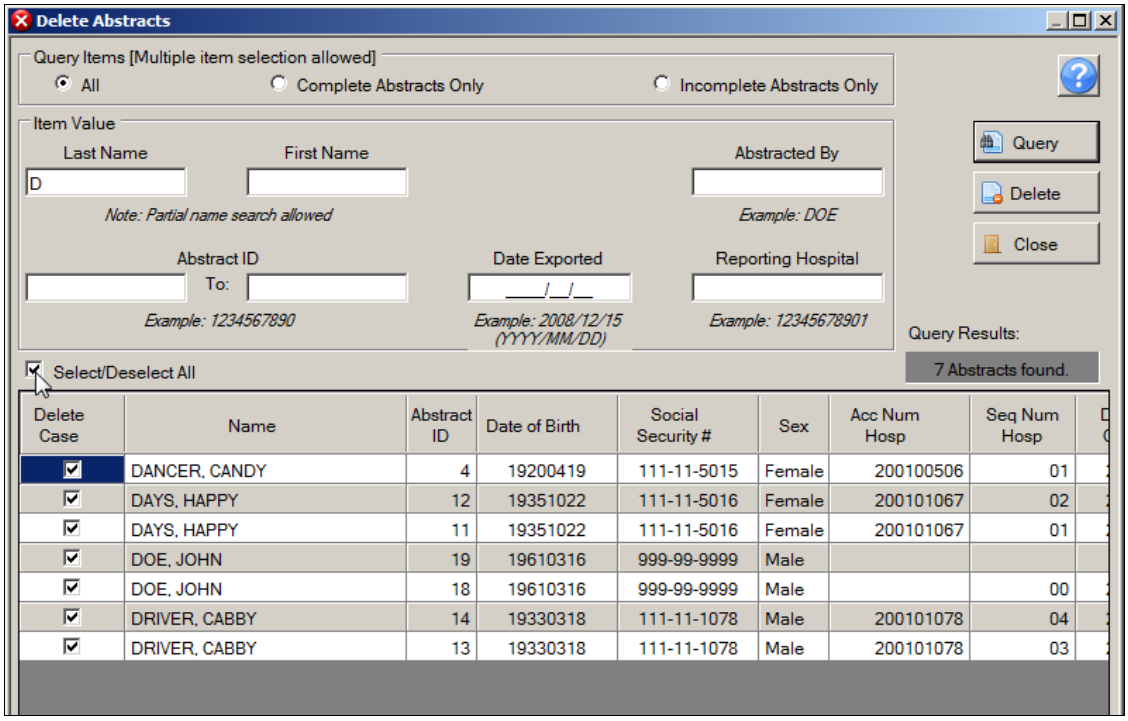
   Result: The **Delete Abstracts** window opens.



2. Abstracts to be deleted can be queried for via various search criteria: patient name, Abstractor's initials, Abstract Reference ID, Reporting Facility, and export date.

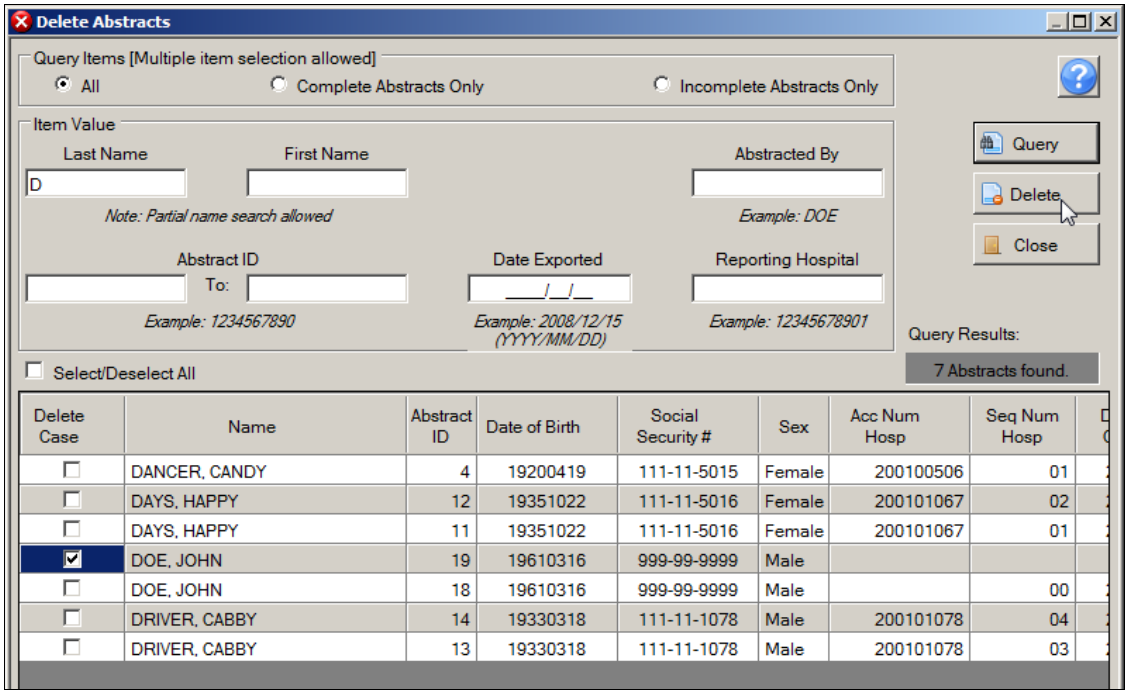
3. Enter your search criteria, and click **Query**. In the example shown, the abstract for the patient named John Doe is being searched for and deleted, so a D is entered in the patient Last Name box.

   Result: Abstracts that match the specified search criteria are displayed in the lower portion of the window. Note that all abstracts listed are selected for deletion. In the example shown, all patient abstracts with the last name beginning with D are displayed and selected for deletion.

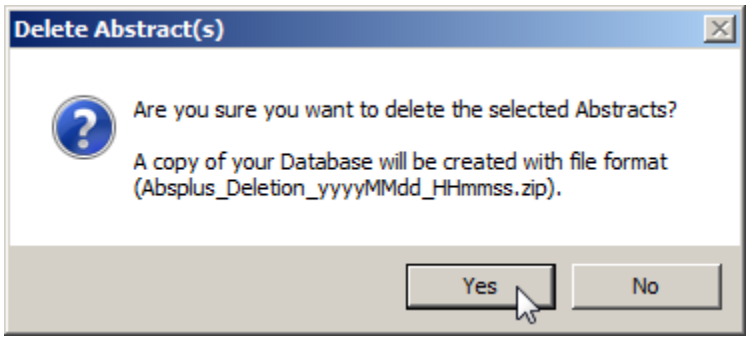


4. To select an individual abstract for deletion from the displayed list, click **Select/Deselect All**. **Result**: All abstracts in the window are deselected.

5. Select individual abstracts for deletion by checking the **Delete Case** check box for the abstract(s), and click **Delete**.

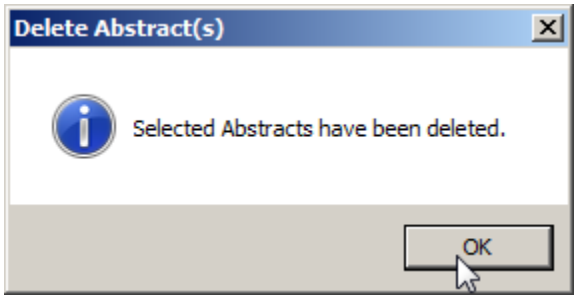


Result: The system verifies that you would like to delete the selected abstract(s), and creates a backup database.



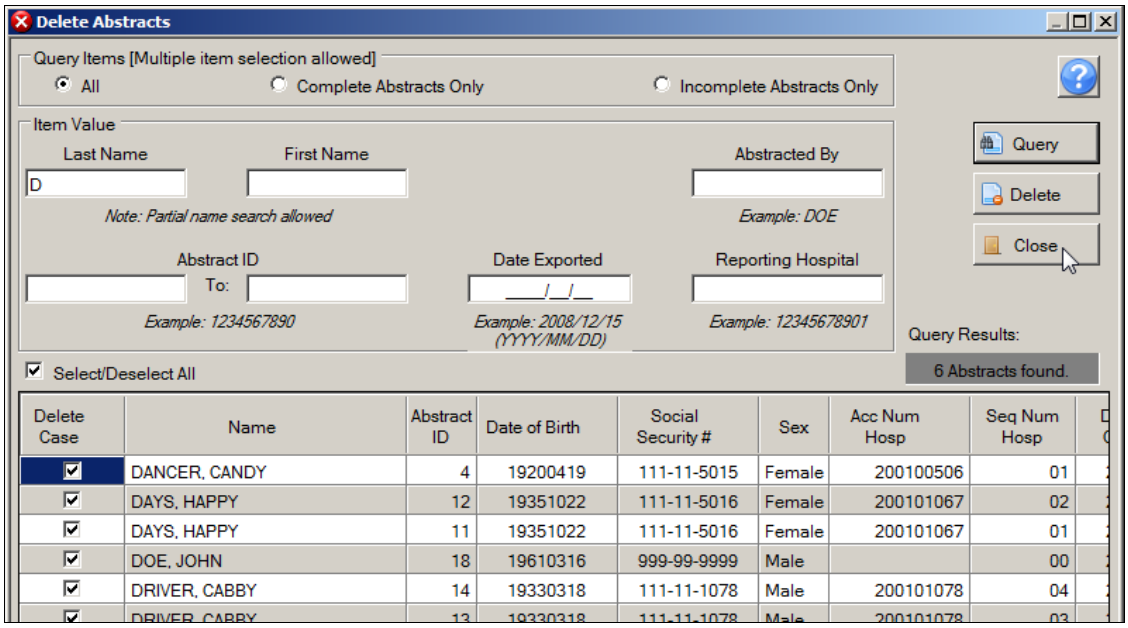
6. Click **Yes**.

   Result: The system lets you know that the abstract has been deleted.



7. Click **OK**.

Result: You are returned to the Delete Abstracts window, where the abstract(s) has been deleted from the list.



8. When you have finished deleting abstracts click **Close** to close the Delete Abstracts window.

Chapter 11: Running Reports

Learning Objectives

In this chapter, you will learn:

- To identify the different reports you can run using Abstract Plus
- Open an Abstract Plus report, and use the various Report Viewer window options to maximize your report viewing experience
- Become familiar with the all of the different file formats in which reports can be saved

Available Reports

The abstracting features of Abstract Plus are supported by a few standard, easy-to-understand reports that can help facilitate and track abstracting activities. The reports included can be upon request using the Reports menu item. The available abstract reports are described in the table below.

Report	Description
Accession Register	Includes a line listing of all abstracts in the database, sorted by reporting hospital and accession number
Patient Index	Includes a line listing of all abstracts in the database, sorted alphabetically by name
Selected Cases	Line listing report which includes abstracts based on user-specified criteria
Status Report (Count of Cases) Summary…	Includes the total number of complete and incomplete abstracts by export status within a user-specified date range
Completion Status of Abstracts by month	Includes abstract completion status by year and month of Date of Adm/1st Contact within a user-specified date range

The Report Wizard, Edit Custom Report and Report Generator Help are not available in Abstract Plus version 3.2.1.0.

Opening Reports

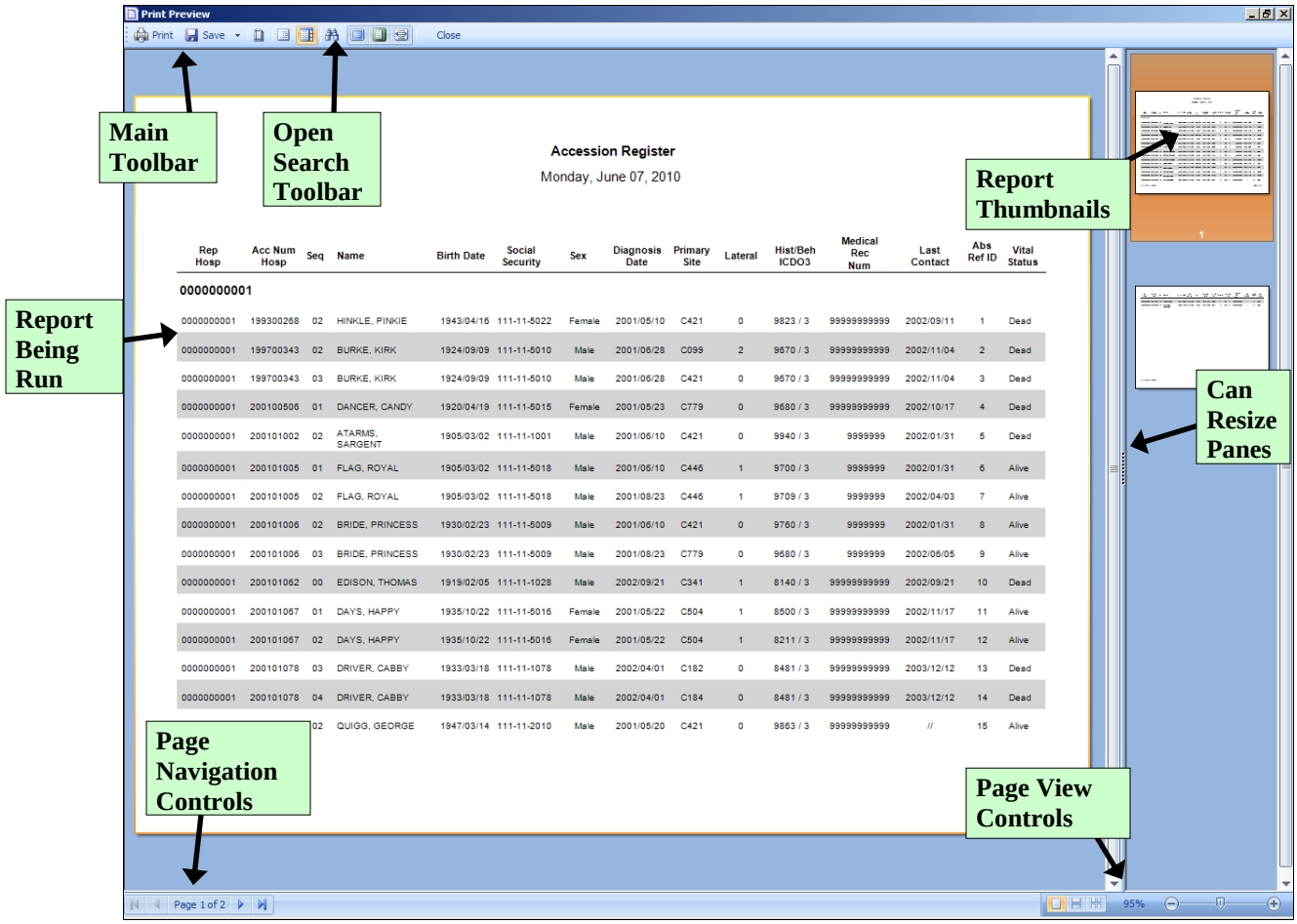
To open any of the various abstract reports, complete these steps.

1. All abstract reports can be opened in two ways.
    a. Click on the **Reports** menu, and select the report of interest.

b. Use the appropriate **keystroke** designated on the Reports menu to open the report of interest. For example, to open the Accession Register Report, use the keystroke **Alt+Shift+A.**

Result: The report of interest opens in the Abstract Plus **Report Viewer** window.

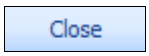
Viewing Reports – The Report Viewer Window



The Abstract Plus Report Viewer window is divided into 2 main sections: a window in which to view reports on the left, and a pane for viewing report thumbnails on the right. When you left-click and hold your mouse on the vertical divider bar in the center of the window, a splitter appears which you can drag to the left or right to resize the view report and thumbnails views.

The Main Toolbar

The Report Viewer Main Toolbar includes icons to print and save the report being viewed, as well as, modify the current view of the report. The following table describes the function of each of the icons on the Main Toolbar, as well as, listing keystroke equivalents where available for each function.

Icon	Keystroke	Function
	Ctrl+P	Print the report being viewed; opens the print dialog window
	Ctrl+O	Save the report being viewed to various file formats
	Ctrl+Shift+S	Change report page setup: size, orientation and margins
	Ctrl+B	Show/hide the tree of bookmarks of the report being viewed; bookmarks are displayed by default---if there are no bookmarks in the report the Report Viewer will automatically hide the tree of bookmarks
	Ctrl+T	Show/hide the thumbnail view of reports in the pane on the right
	Ctrl+F	Search; Open the Search Toolbar
	F2	View the report in full screen mode
	F3	View the report one page at-a-time
	F4	View the report 2 pages at-a-time
	No keystroke	View multiple pages of the report at-a-time; specify 1x2, 2x3, etc.
	F5	Control page width; when clicked report will enlarge to the page width of Report Viewer window
	No keystroke	Close a report

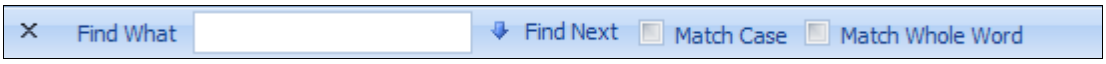
Page Navigation Controls

Report page navigation controls are located in the lower left-hand corner of the Report Viewer window and help you navigate through the various pages of the report being viewed. The following table describes the function of each of the page navigation controls.

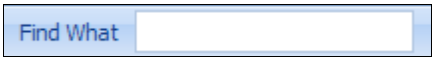
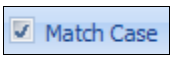
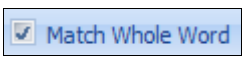
Control	Function
	View the first page of the report being viewed
	View the previous page of the report being viewed
	Lists the page number of the current page of the report being viewed
	View the next page of the report being viewed
	View the last page of the report being viewed

The Search Toolbar

The search panel is used to search for specific text within the report. To access feature, click the binocular icon  on the main toolbar.



When opened, the Search Toolbar is located in the lower left-hand corner of the Report Viewer window directly over the Page Navigation controls. The following table describes the function of each of the Search toolbar icons.

Icon	Function
	Closes the Search Toolbar
	Enter the term being searched for in the Find What box
	When clicked, searches the report and finds the next occurrence of the search term entered in the Find What box
	When checked, the search is repeated with case of the search term considered
	When checked, the search is repeated with only whole words of the search term considered

Page View Controls

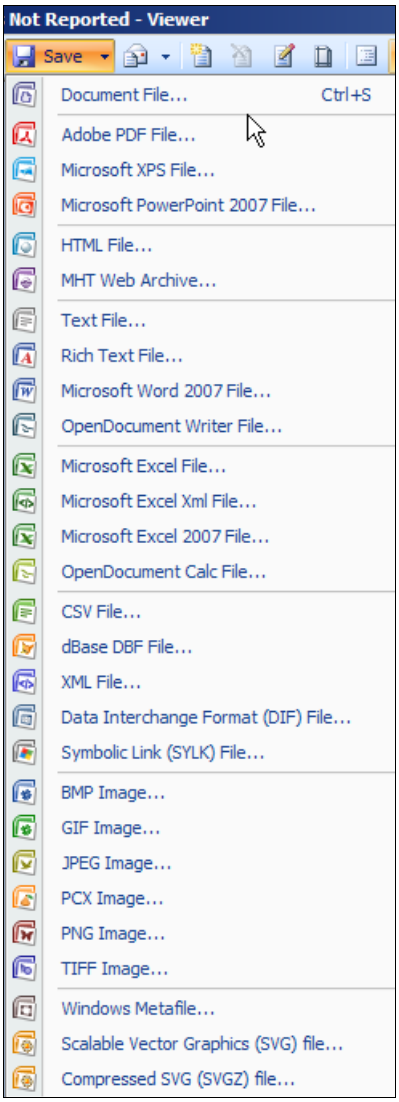
Report page view controls are located in the lower right-hand corner of the Report Viewer window, and include icons to help you control how many pages of the report to view, as well as, to zoom in or out on the current report being viewed. The following table describes the function of each of the page view controls.

Control	Keystroke	Function
	Shift+F2	Single Page: View the report one page at-a-time
	Shift+F3	Continuous: View the report with all pages displayed continuously
	Shift+F4	Multiple Pages: based on the selected zoom, all possible pages are displayed to fill the viewer window
	No keystroke	Selected Zoom: View the report at the percent size specified

Saving Reports

In order to facilitate the utilization of the information included in the Abstract Plus reports, Abstract Plus offers an extensive number of file formats in which the reports can be saved. You can save the reports in different file formats to further analyze or change the format of the data, or you can save the report as an image file to be placed in documents and presentations.

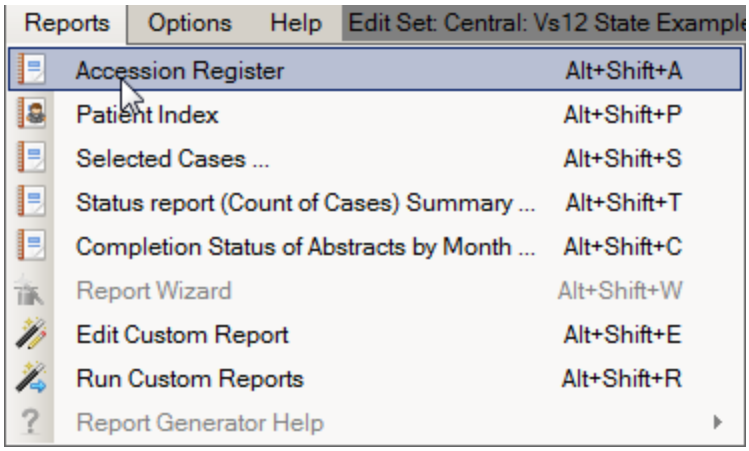
You can save your audit report in any of the file formats listed under the Save As icon on the Main Toolbar of the Report Viewer.



Accession Register Report

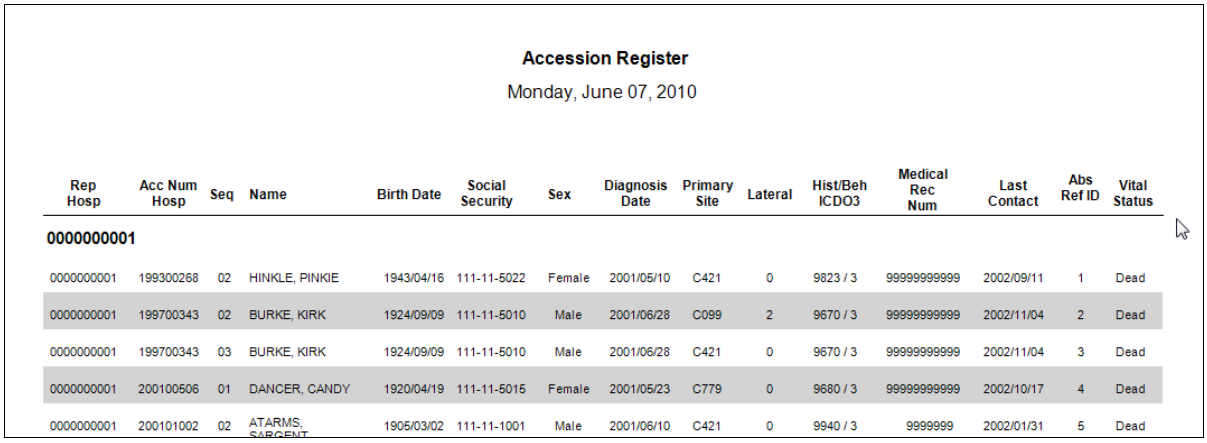
To run the Accession Register report, complete these steps.

1. The Accession Register report can be opened in two ways.
    a. Click on the **Reports** menu, and select **Accession Register**.



b. Use the keystroke **Alt+Shift+A**.

Result: The **Accession Register report** opens in the Report Viewer window. Notice that the accession numbers are displayed in ascending order and grouped by the reporting hospital.



Accession Register

Monday, June 07, 2010

Rep Hosp	Acc Num Hosp	Seq	Name	Birth Date	Social Security	Sex	Diagnosis Date	Primary Site	Lateral	Hist/Beh ICDO3	Medical Rec Num	Last Contact	Abs Ref ID	Vital Status
0000000001														
0000000001	199300268	02	HINKLE, PINKIE	1943/04/16	111-11-5022	Female	2001/05/10	C421	0	9823 / 3	99999999999	2002/09/11	1	Dead
0000000001	199700343	02	BURKE, KIRK	1924/09/09	111-11-5010	Male	2001/06/28	C099	2	9670 / 3	99999999999	2002/11/04	2	Dead
0000000001	199700343	03	BURKE, KIRK	1924/09/09	111-11-5010	Male	2001/06/28	C421	0	9670 / 3	99999999999	2002/11/04	3	Dead
0000000001	200100506	01	DANCER, CANDY	1920/04/19	111-11-5015	Female	2001/05/23	C779	0	9680 / 3	99999999999	2002/10/17	4	Dead
0000000001	200101002	02	ATARMS, SARGENT	1905/03/02	111-11-1001	Male	2001/06/10	C421	0	9940 / 3	9999999	2002/01/31	5	Dead

The Accession Register report includes these fields:

Columns	Description
Rep Hosp	COC code for the reporting facility of the abstract
Acc Num Hosp	Hospital Accession Number for the tumor
Seq	Hospital Sequence Number for the tumor
Name	Name of Patient (Last, First)
Birth Date	Patient's date of birth
Social Security	Patient's social security number
Sex	Patient's sex
Diagnosis Date	Diagnosis date of the tumor
Primary Site	ICD-O-3 topography code describing the location of the tumor

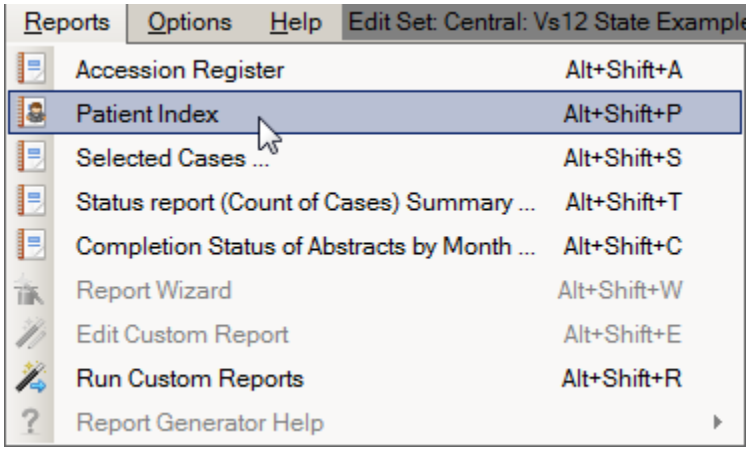
Columns	Description
Lateral	Laterality code for the laterality of the tumor
Hist/Beh ICDO3	ICD-O-3 histology and behavior codes for the tumor
Medical Rec Num	Patient's medical record number
Last Contact	Date of Last Contact with the patient
Abs Ref ID	A unique, system-generated number identifying the abstract
Vital Status	Patient's vital status

2. When you are done viewing the report, click **Print** to print the report, **Save** to save the report, or **Close** to close the report.

Patient Index Report

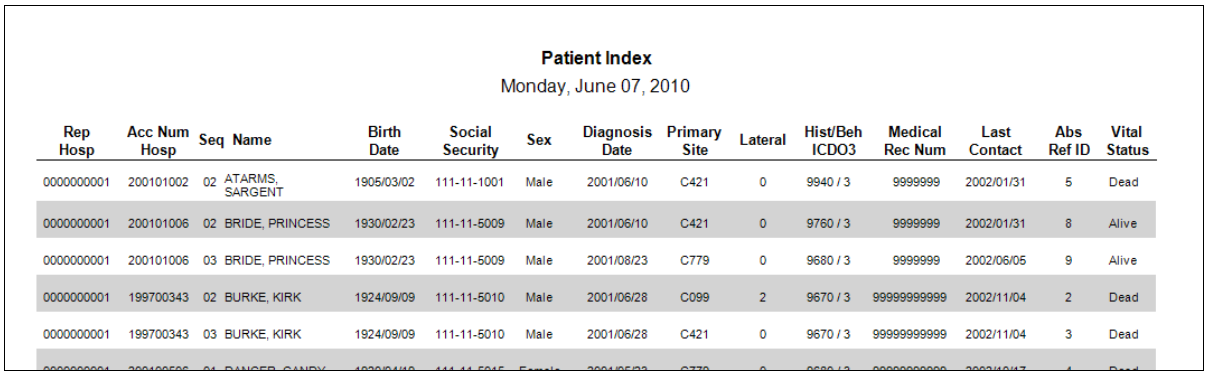
To run the Patient Index report, complete these steps.

1. The Patient Index report can be opened in two ways.
   a. Click on the **Reports** menu, and select **Patient Index**.



   b. Use the keystroke **Alt+Shift+P**.

Result: The **Patient Index report** opens in the Report Viewer window. Notice that the abstracts are displayed in alphabetic order by the name.



Patient Index

Monday, June 07, 2010

Rep Hosp	Acc Num Hosp	Seq	Name	Birth Date	Social Security	Sex	Diagnosis Date	Primary Site	Lateral	Hist/Beh ICDO3	Medical Rec Num	Last Contact	Abs Ref ID	Vital Status
0000000001	200101002	02	ATARMS, SARGENT	1905/03/02	111-11-1001	Male	2001/06/10	C421	0	9940 / 3	9999999	2002/01/31	5	Dead
0000000001	200101006	02	BRIDE, PRINCESS	1930/02/23	111-11-5009	Male	2001/06/10	C421	0	9760 / 3	9999999	2002/01/31	8	Alive
0000000001	200101006	03	BRIDE, PRINCESS	1930/02/23	111-11-5009	Male	2001/08/23	C779	0	9680 / 3	9999999	2002/06/05	9	Alive
0000000001	199700343	02	BURKE, KIRK	1924/09/09	111-11-5010	Male	2001/06/28	C099	2	9670 / 3	99999999999	2002/11/04	2	Dead
0000000001	199700343	03	BURKE, KIRK	1924/09/09	111-11-5010	Male	2001/06/28	C421	0	9670 / 3	99999999999	2002/11/04	3	Dead

The Patient Index report includes these fields.

Columns	Description
Rep Hosp	COC code for the reporting facility of the abstract
Acc Num Hosp	Hospital Accession Number for the tumor
Seq	Hospital Sequence Number for the tumor
Name	Name of Patient (Last, First)
Birth Date	Patient's date of birth
Social Security	Patient's social security number
Sex	Patient's sex
Diagnosis Date	Diagnosis date of the tumor
Primary Site	ICD-O-3 topography code describing the location of the tumor
Lateral	Laterality code for the laterality of the tumor
Hist/Beh ICDO3	ICD-O-3 histology and behavior codes for the tumor
Medical Rec Num	Patient's medical record number
Last Contact	Date of Last Contact with the patient
Abs Ref ID	A unique, system-generated number identifying the abstract
Vital Status	Patient's vital status

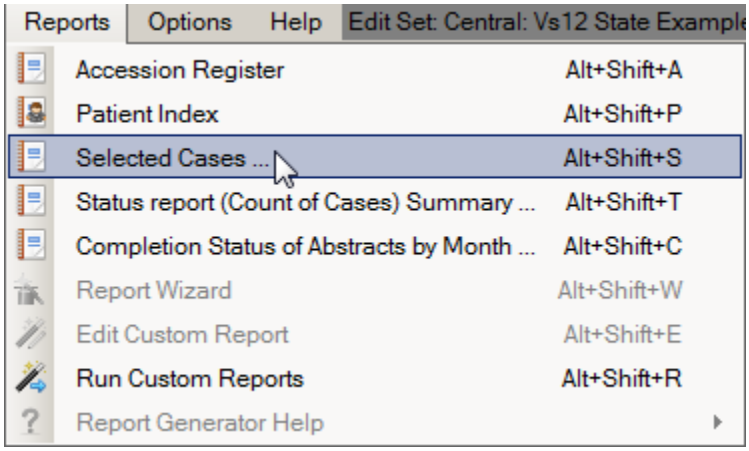
2. When you are done viewing the report, click **Print** to print the report, **Save** to save the report, or **Close** to close the report.

Selected Cases Report

To run the Selected Cases report, complete these steps.

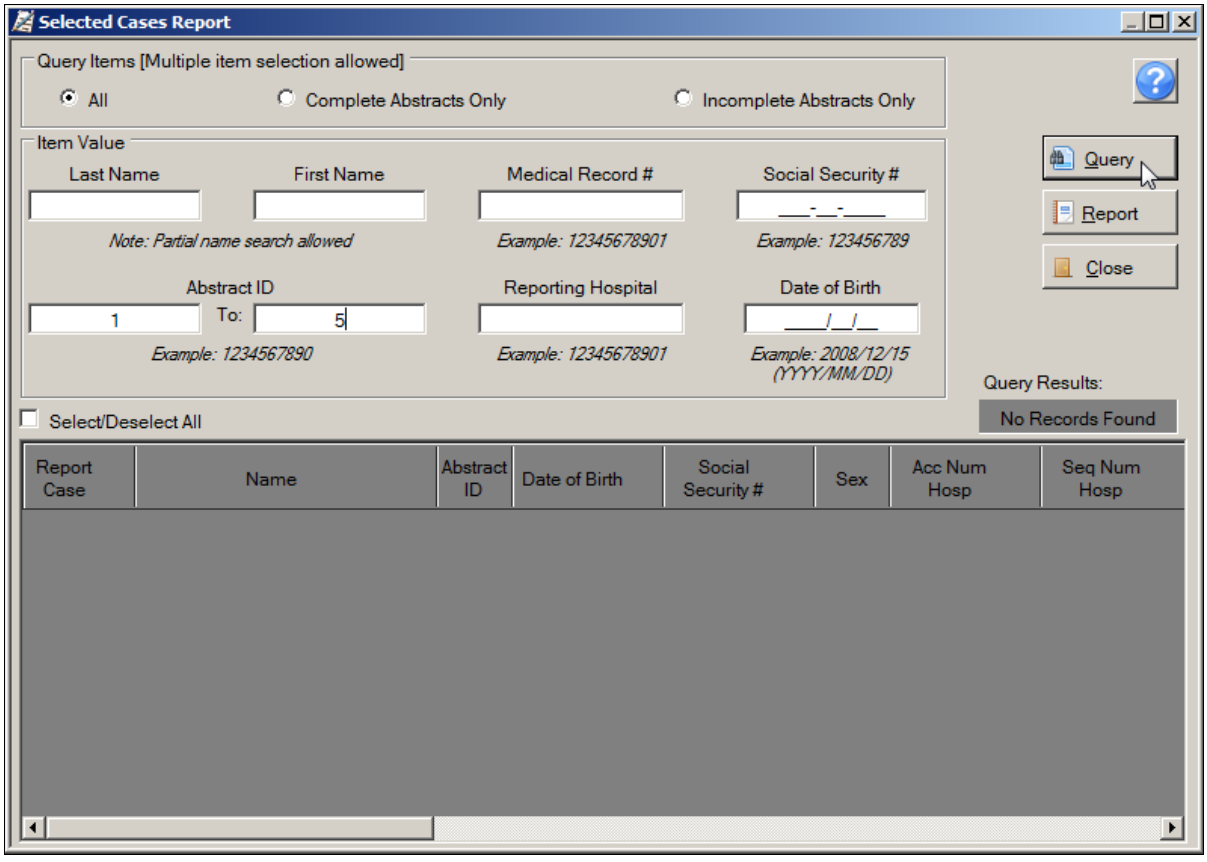
1. The Selected Cases report can be opened in two ways.

a. Click on the **Reports** menu, and select **Selected Cases**.



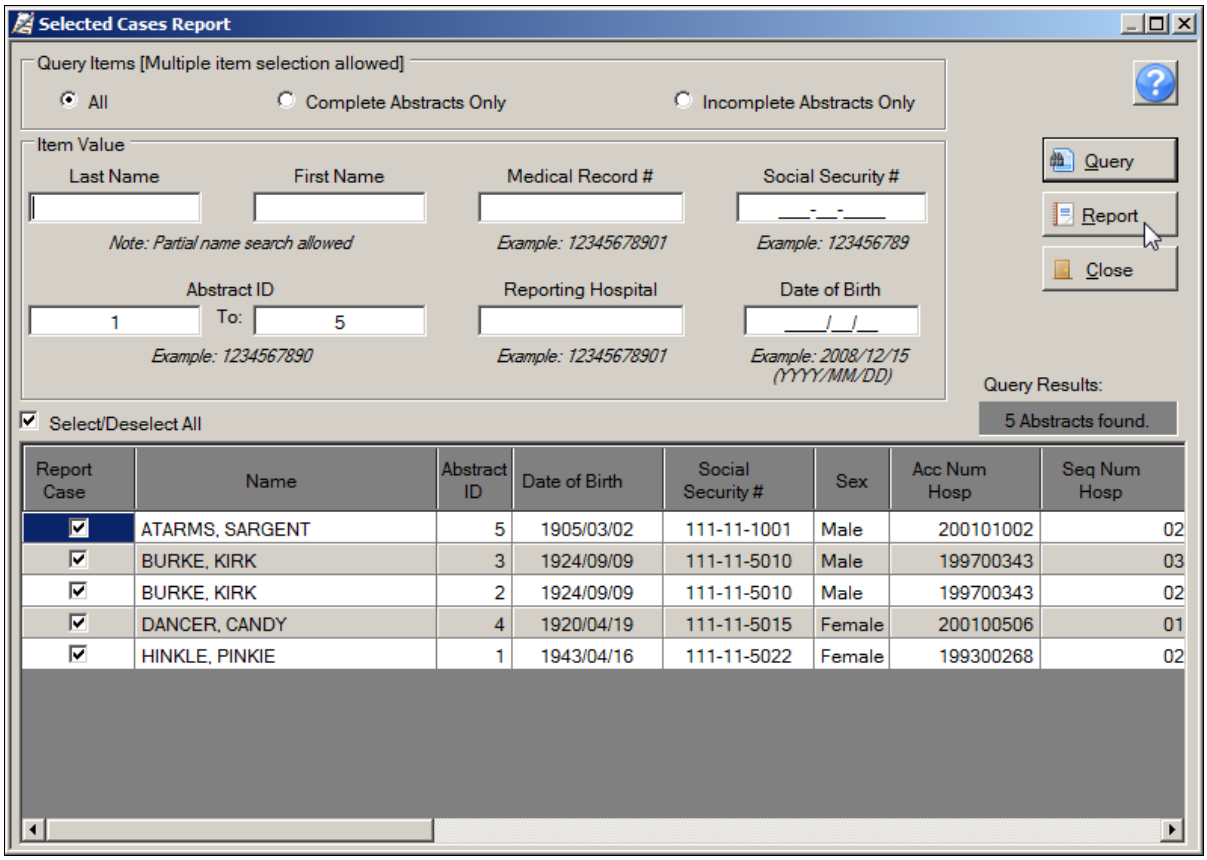
b. Use the keystroke **Alt+Shift+S**.

Result: The system displays a window to enter report criteria.



2. Enter report **selection criteria**, and click **Query**. Available report selection criteria include patient last name, first name, medical record number, social security number, and date of birth, as well as, Abstract Reference ID, reporting hospital, and abstract completion status. In the example shown, the report criterion of Abstract Reference ID numbers 1 to 5 is being specified.

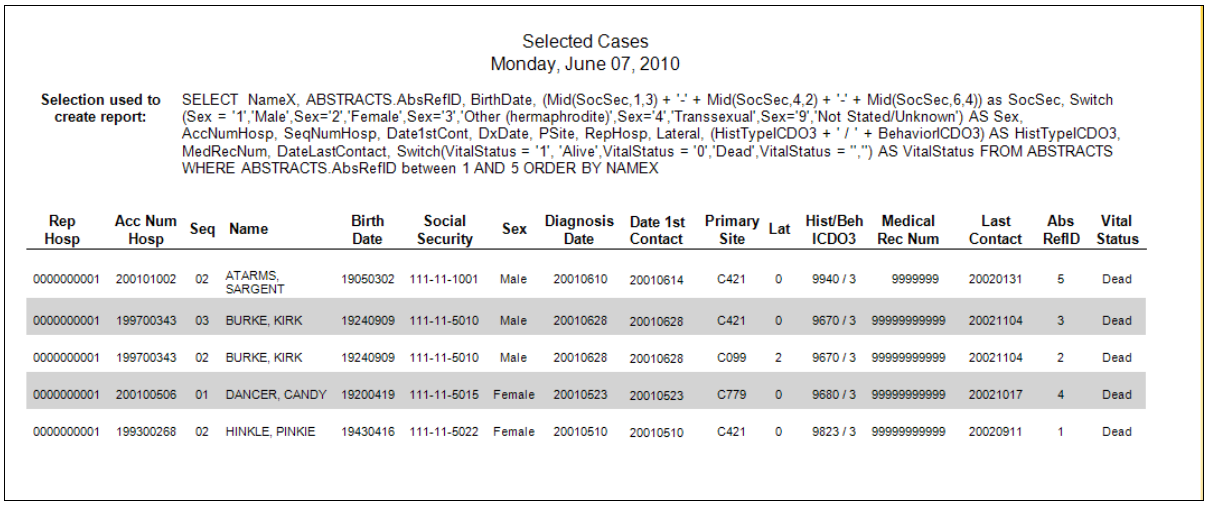
Result: The system displays the cases that meet the entered criteria in the query result window.



You can further restrict the cases included in the report by un-checking the **Report Case checkbox** in the left-most column of the query window for those cases you would like to exclude from the report.

Click **Report**.

Result: The **Selected Cases report** opens in the Report Viewer window. Notice that it displays only the cases that fall within the specified range. The system also records and displays the SQL statement used to create the report at the top of the report.



Selected Cases
Monday, June 07, 2010

Selection used to create report: SELECT NameX, ABSTRACTS.AbsRefID, BirthDate, (Mid(SocSec,1,3) + '-' + Mid(SocSec,4,2) + '-' + Mid(SocSec,6,4)) as SocSec, Switch (Sex = '1','Male',Sex='2','Female',Sex='3','Other (hermaphrodite)',Sex='4','Transsexual',Sex='9','Not Stated/Unknown') AS Sex, AccNumHosp, SeqNumHosp, Date1stCont, DxDate, PSite, RepHosp, Lateral, (HistTypeICDO3 + ' / ' + BehaviorICDO3) AS HistTypeICDO3, MedRecNum, DateLastContact, Switch(VitalStatus = '1', 'Alive',VitalStatus = '0','Dead',VitalStatus = '','') AS VitalStatus FROM ABSTRACTS WHERE ABSTRACTS.AbsRefID between 1 AND 5 ORDER BY NAMEX

Rep Hosp	Acc Num Hosp	Seq	Name	Birth Date	Social Security	Sex	Diagnosis Date	Date 1st Contact	Primary Site	Lat	Hist/Beh ICDO3	Medical Rec Num	Last Contact	Abs RefID	Vital Status
0000000001	200101002	02	ATARMS, SARGENT	19050302	111-11-1001	Male	20010610	20010614	C421	0	9940 / 3	9999999	20020131	5	Dead
0000000001	199700343	03	BURKE, KIRK	19240909	111-11-5010	Male	20010628	20010628	C421	0	9670 / 3	99999999999	20021104	3	Dead
0000000001	199700343	02	BURKE, KIRK	19240909	111-11-5010	Male	20010628	20010628	C099	2	9670 / 3	99999999999	20021104	2	Dead
0000000001	200100506	01	DANCER, CANDY	19200419	111-11-5015	Female	20010523	20010523	C779	0	9680 / 3	99999999999	20021017	4	Dead
0000000001	199300268	02	HINKLE, PINKIE	19430416	111-11-5022	Female	20010510	20010510	C421	0	9823 / 3	99999999999	20020911	1	Dead

a. The Selected Cases Report includes these fields.

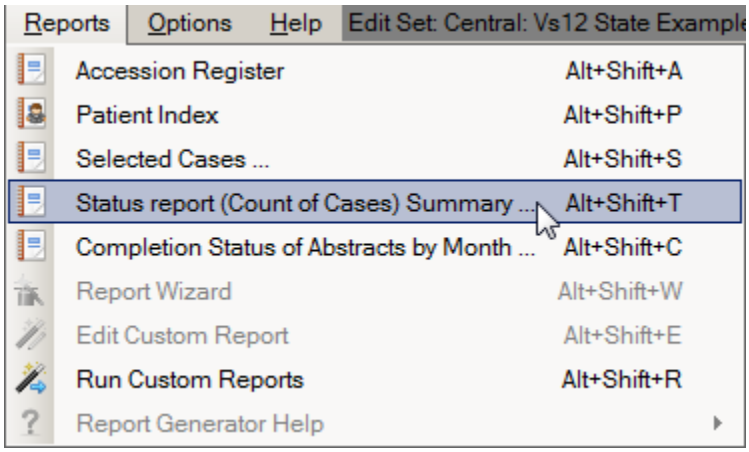
Columns	Description
Rep Hosp	COC code for the reporting facility of the abstract
Acc Num Hosp	Hospital Accession Number for the tumor
Seq	Hospital Sequence Number for the tumor
Name	Name of Patient (Last, First)
Birth Date	Patient's date of birth
Social Security	Patient's social security number
Sex	Patient's sex
Diagnosis Date	Diagnosis date of the tumor
Date 1st Contact	Date of first contact with the patient
Primary Site	ICD-O-3 topography code describing the location of the tumor
Lateral	Laterality code for the laterality of the tumor
Hist/Beh ICDO3	ICD-O-3 histology and behavior codes for the tumor
Medical Rec Num	Patient's medical record number
Last Contact	Date of Last Contact with the patient
AbsRefID	A unique, system-generated number identifying the abstract
Vital Status	Patient's vital status

3. When you are done viewing the report, click **Print** to print the report, **Save** to save the report, or **Close** to close the report.

Status Report (Count of Cases) Summary

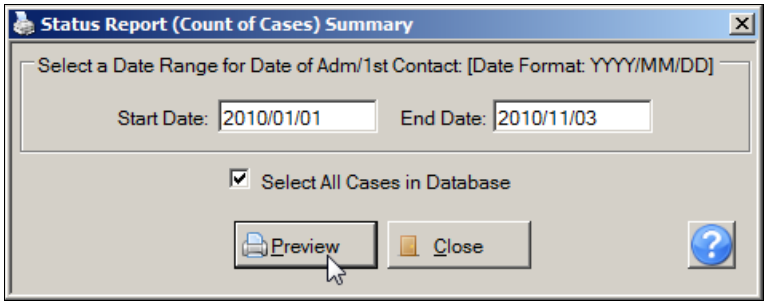
To run the Status Report (Count of Cases) Summary report, complete these steps.

1. Status Report (Count of Cases) Summary report can be opened in two ways.
   a. Click on the **Reports** menu, and select **Status report (Count of Cases) Summary**.



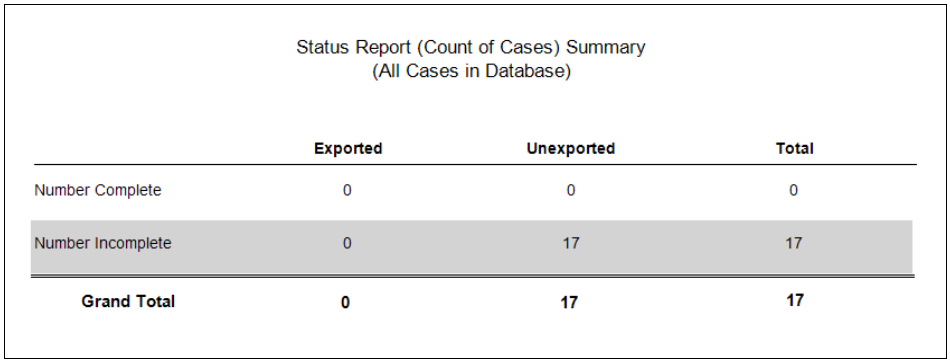
   b. Use the keystroke **Alt+Shift+T**.

Result: The system displays a window where you enter a date range, or select all cases in the database for the report.



2. Enter the desired **date range**, or check the Select All Cases in Database check box to include all abstracts in the database, and click **Preview**. In the example shown all abstracts in the database are being included in the report.

   Result: The **Status Report (Count of Cases) Summary report** opens in the Report Viewer window displays the summary information for the abstracts.



Status Report (Count of Cases) Summary
(All Cases in Database)

	Exported	Unexported	Total
Number Complete	0	0	0
Number Incomplete	0	17	17
Grand Total	**0**	**17**	**17**

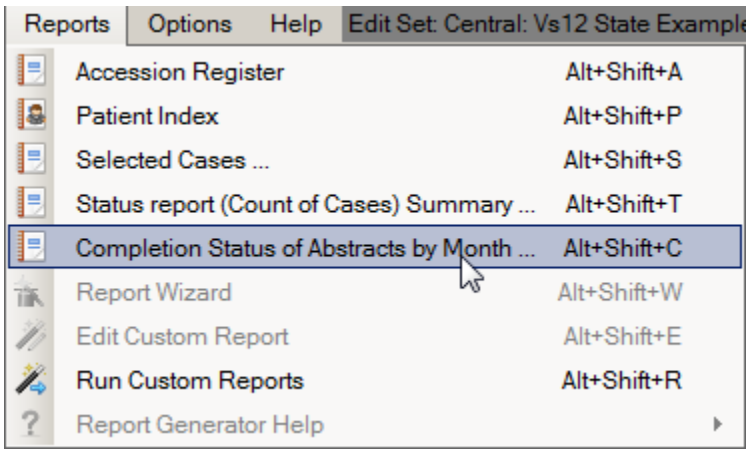
The Status Report (Count of Cases) Summary report includes the number of incomplete and complete abstracts, stratified by abstract export status.

3. When you are done viewing the report, click **Print** to print the report, **Save** to save the report, or **Close** to close the report.

Completion Status of Abstracts by Month

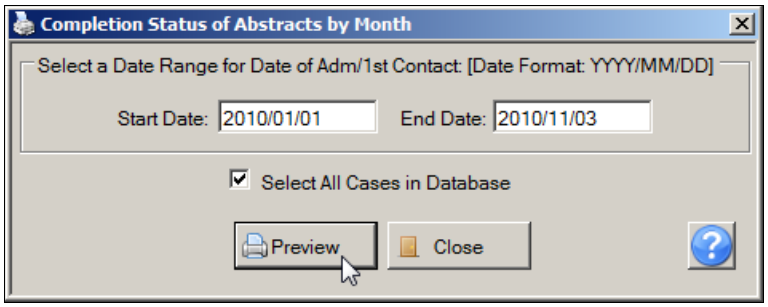
To run the Completion Status of Abstracts by Month report, complete these steps:

1. The Completion Status of Abstracts by Month report can be opened in two ways:
   a. Click on the **Reports** menu, and select **Completion Status of Abstracts by Month**.



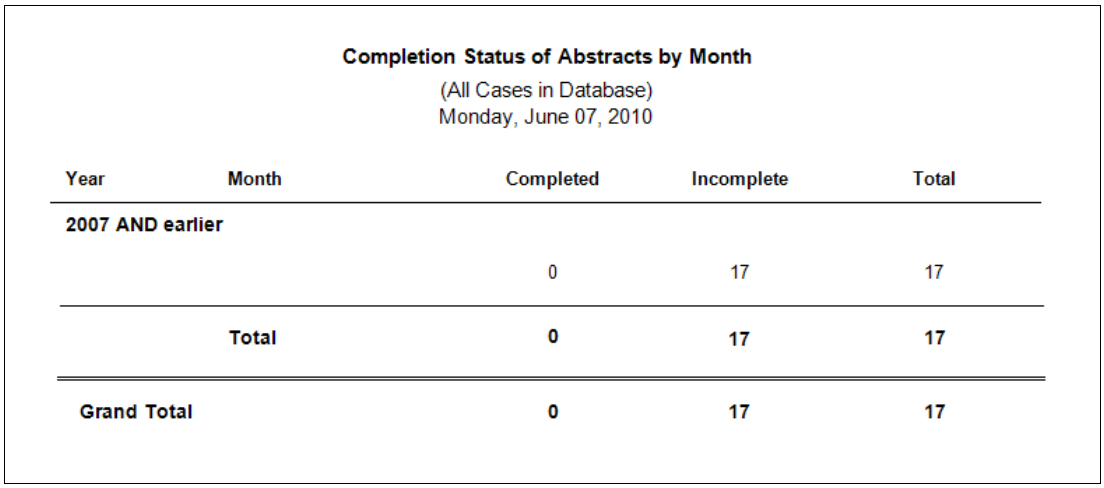
   b. Use the keystroke **Alt+Shift+C**.

Result: The system displays a window where you enter a date range, or select all cases in the database for the report.



2. Enter the desired **date range**, or check the Select All Cases in Database check box to include all abstracts in the database, and click **Preview**. In the example shown all abstracts in the database are being included in the report.

   Result: The **Completion Status of Abstracts by Month report** opens in the Report Viewer window displays the summary information for the abstracts.



Completion Status of Abstracts by Month

(All Cases in Database)
Monday, June 07, 2010

Year	Month	Completed	Incomplete	Total
2007 AND earlier				
		0	17	17
	Total	**0**	**17**	**17**
Grand Total		**0**	**17**	**17**

   The Completion Status of Abstracts by Month report includes the number of incomplete and complete abstracts, stratified by diagnosis month or year, depending on the range of dates specified.

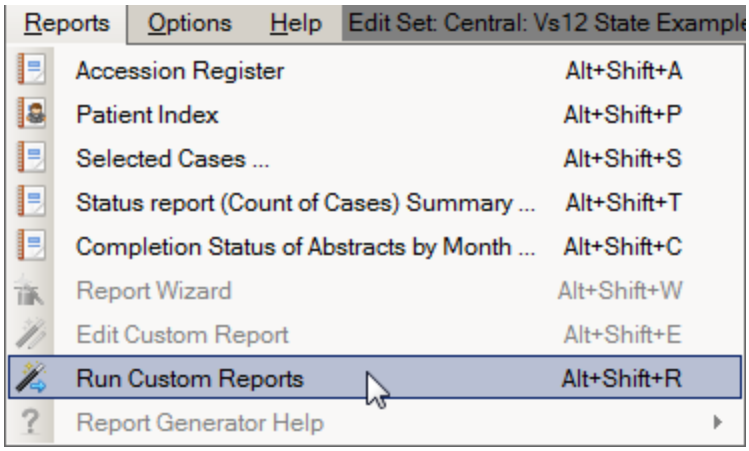
3. When you are done viewing the report, click **Print** to print the report, **Save** to save the report, or **Close** to close the report.

Running Custom Reports

Abstract Plus version 3.2.1.0 offers a custom reports feature. This feature is being implemented in phases. In the first release custom reports that have been generated by the Abstract Plus Development team at CDC can be opened by Abstract Plus users. The various other custom report features, such as being able to generate your own report or modify an existing one, will be implemented in future versions of Abstract Plus.

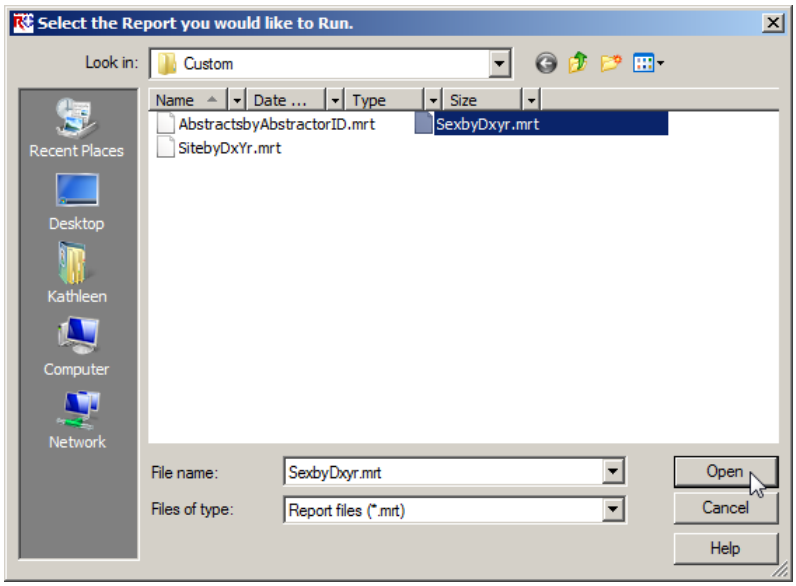
To open and view a custom report, complete these steps.

1. The custom report can be opened in two ways.
   a. Click on the **Reports** menu, and select **Run Custom Reports**.



b. Use the keystroke **Alt+Shift+R**.

Result: The **Select the Report you would like to Run** window opens.



2. Select the custom report you would like to open and click **Open**.

   Result: The **selected report opens** in the Abstract Plus Report viewer window.

3. When you are done viewing the report, click **Print** to print the report, **Save** to save the report, or **Close** to close the report.

Chapter 12: Submitting Changes

Learning Objectives

In this chapter, you will learn:

- The types of changes that should be submitted as an Update to the MCSP
- How to submit corrections, which includes updating or the correcting of previously submitted information to the MCSP

When/How to Submit Changes

If a cancer case is reported, and later determined not to be reportable, OR the information to resolve an unknown variable has been obtained OR the information for a particular variable was later determined to be submitted incorrectly, a correction to the previously submitted report MUST be forwarded.

Submitting changes ensures the most accurate information is available to users of the MCSP data by enabling reporting facilities to provide updated or corrected information after a record has been accessioned by the MCSP.

It is especially important to send corrections when there are changes in the following:

- Date of Birth
- Social Security Number
- Date of Diagnosis
- Primary Site
- Laterality
- Histology
- Tumor Grade
- Stage
- First course of treatment information

The steps for how to change information and submit corrections as Updates to the MCSP are as follows.

1. After corrections are made to records previously submitted to the MCSP, print the abstract that coincides with the patient's corrected information from the Abstract Plus software (see Printing an Abstract.)

2. Highlight the corrected information on the printed abstract.

3. Mail the abstract(s) to Elaine Snyder at:

Michigan Cancer Surveillance Program
Vital Records & Health Data Development Section
Capitol View Building, 2nd Floor
201 Townsend St.
Lansing, MI 48933
Attn: Elaine Snyder

Appendix A: Standard Keyboard Shortcuts

Function	Keyboard Combination
Menus	
File Menu	Alt+ F
Administration Menu	Alt+ M
Utilities Menu	Alt+ U
Reports Menu	Alt+ R
Options Menu	Alt+ O
Help Menu	Alt+ H
Right-Click Menu:	
Search Help / Field Context	F1
Edits Information for current field	F2
Field Message	F3
Special Field Lookup	F4
CS or Age calculations	F5
Run EDITS on current Abstract	F8
Undo text change	Ctrl+ Z
Cut selected text	Ctrl+ X
Copy selected text	Ctrl+ C
Paste text from clipboard	Ctrl+ V
Delete selected text	Alt+ D
Select All text in entry field	Alt+ A
Move to first Text Field	Ctrl+ T
Section Headings	Alt+ S
Display Types	Alt+ T
General	
Open a pull-down data item listing	Alt+ Down Arrow
Move to next field	Enter or Tab
Move to previous field	Shift+Enter or Shift+Tab

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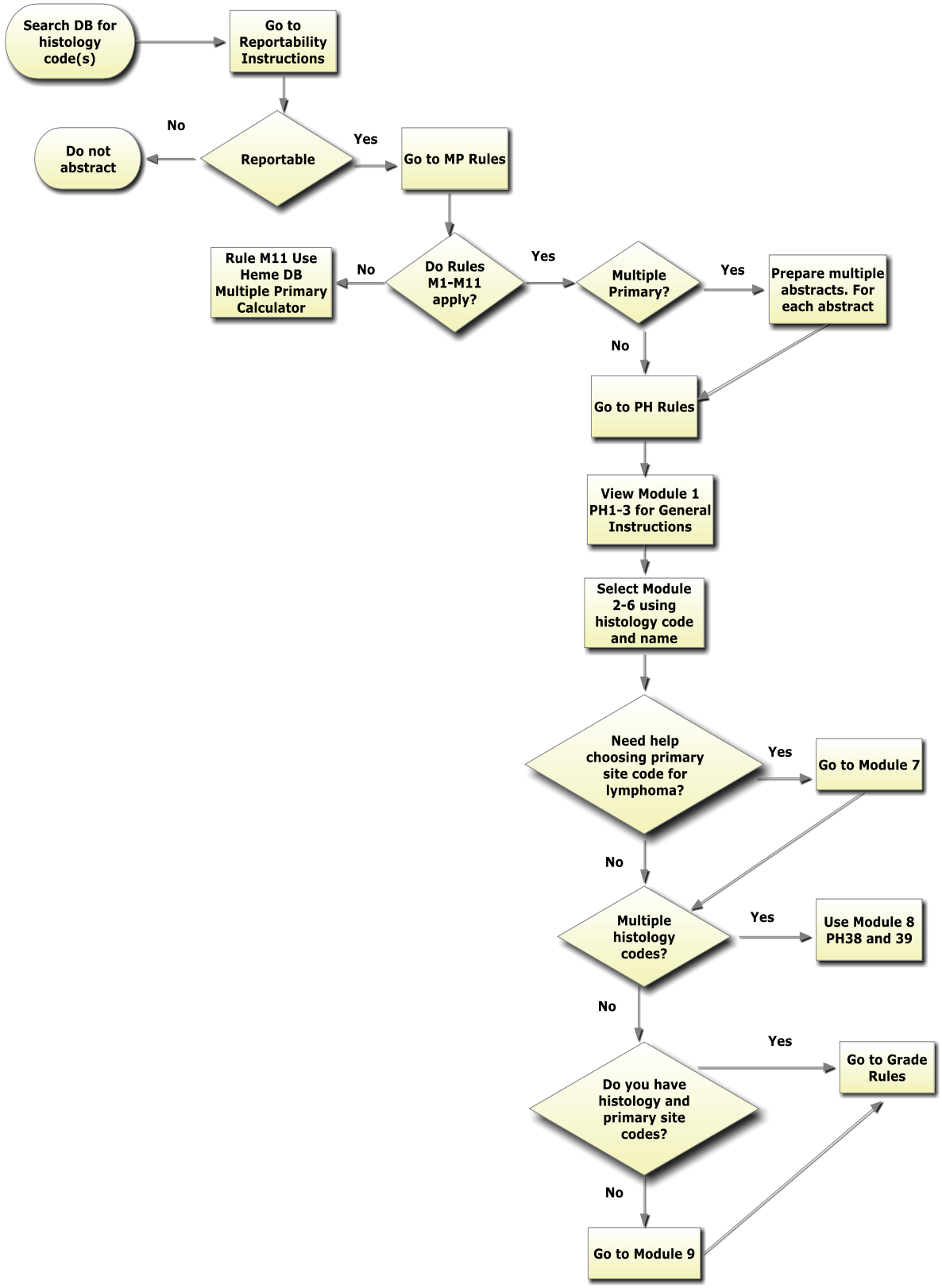
Appendix B: Flowchart for Hematopoietics



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